

PUBLIC HEALTH

LONDON: THE SOCIETY OF MEDICAL OFFICERS OF HEALTH
Tavistock House South, Tavistock Square, W.C.1



No. 1.-Vol. LXVI.

MONTHLY PRICE 2s. 6d.
ANNUAL SUBSCRIPTION 31s. 6d.

OCTOBER-1952

Special Requirements

In certain circumstances the need for an increased supply of vitamins may arise. An outstanding example is the need for additional vitamins during pregnancy. Vitamin supplements are frequently prescribed at ante-natal clinics, the B complex having proved to be of special importance.

Many doctors consider that it is preferable to administer vitamins in a natural form. Marmite yeast extract is therefore often ordered as a supplementary source of B₂ vitamins since, in addition to riboflavin (1.5 mg. per oz.) and nicotinic acid (16.5 mg. per oz.), it supplies the other less well known B₂ factors.

MARMITE yeast extract

Obtainable from Chemists and Grocers
Special terms for packs for hospitals, welfare centres and schools
THE MARMITE FOOD EXTRACT CO., LTD.
35 Seething Lane, London, E.C.3

PH5205

Literature on request

THE B.D.H. TONIC FOR CHILDREN

4 fl. oz. bottles 3s. 5d. Price in
Great Britain to the Medical Profession

Ferbelan, a new pleasantly flavoured syrup, is ideal
for the treatment of lassitude, decreased alert-
ness and lack of appetite in children of all ages.

'Ferbelan'

Each teaspoonful contains iron and ammonium
citrate 3 grains, vitamin B₁ 2 mg., niacinamide 5 mg.,
riboflavine 0.5 mg. and vitamin B₁₂ 2.5 micrograms.

Literature and specimen packings are available from the MEDICAL DEPARTMENT

THE BRITISH DRUG HOUSES LTD. LONDON N.I.

PH5205

The
**BEATSON
MEDICAL**

A bottle of quality. The retention of the vial lip for easy pouring is combined with all the advantages of modern design, including the elimination of internal sharp corners allowing rapid dispersal of sediment.

★ Plain or Graduated Cork Mouth or Screw Capped

BEATSON, CLARK & CO. LTD
MANUFACTURERS OF CHEMICAL AND MEDICAL GLASS
ROTHERHAM • Established 1751 • YORKS.

BCW

Safe Drinking Water

The tens of millions of the Allied armies and air forces were protected from infection by their drinking water being made safe by the Metafilter. The method is simple and sure and the filter is completely cleaned in a few minutes by simple reversal. Sizes from 1 gallon to 10,000 gallons per hour.

METAFILTRATION

THE METAFILTRATION COMPANY LIMITED, BELGRAVE ROAD, HOUNSLOW, MIDDLESEX

PHONE:
HOUNSLOW 1212/3
GRAMS:
METAFILTER, HOUNSLOW

Have you a Caravan Problem in your area?

The National Caravan Council—the only impartial organisation representing all aspects of caravanning—is anxious and willing to assist and advise Local Authorities on caravan problems, and to co-operate with them in ensuring an adequate standard for all sites.

As a temporary solution to the housing problem caravans are being used, and they can also assist the rearmament programme by housing workers at new factories in areas where houses are not at present available.

In addition, caravan holidays are on the increase, with a consequent demand for more caravan sites.

The Council's brochure, "Caravan Sites—A Guide for Local Authorities and Operators," which is a guide and reference for all those interested in and concerned with the running of caravan sites to desirable standards, is available free of charge from Dept. P.H.3.

FOR YOUR INFORMATION caravan manufacturers displaying this badge are approved by the National Caravan Council.



NATIONAL CARAVAN COUNCIL

8 CLARKE'S STREET PICCADILLY W1 Telephone: GROsvenor 1532

NAPT

NAPT HANDBOOK OF TUBERCULOSIS ACTIVITIES IN GREAT BRITAIN AND THE COMMONWEALTH

14th edition—fully revised

The only complete Directory. Tuberculosis Hospitals, Sanatoria and Clinics, Regional Hospital Boards, Hospital Management Committees. Names of medical staff, complete addresses and telephone numbers. With a new and enlarged section on Local Health Authorities, giving Medical Officers of Health, Divisional Medical Officers, Statutory and Voluntary Care Committees.

CLOTHBOUND

Thirty Shillings

NON-PULMONARY TUBERCULOSIS OF BOVINE ORIGIN IN GREAT BRITAIN

By

G. S. WILSON, M.D., F.R.C.P., M.R.C.S., D.P.H.,
Director, Public Health Laboratory Service, Medical
Research Council.

J. W. S. BLACKLOCK, M.D., F.R.P.S.
Professor in Pathology, St. Bartholomew's Hospital Medical
College, London.

L. V. REILLY, B.Sc., M.D., D.P.H.
Bacteriologist to the Northern Ireland Tuberculosis
Authority.

CLOTHBOUND Sixteen Shillings MAPS AND DIAGRAMS

NATIONAL ASSOCIATION FOR THE
PREVENTION OF TUBERCULOSIS
Tavistock House North, London, W.C.1

NEW BOVRIL WEANING FOOD meets long-felt need



4 VARIETIES

- BEEF AND TOMATO
- BEEF AND CARROT
- BEEF AND SPRING CABBAGE
- BEEF AND MIXED VEGETABLES

The makers of Bovril became convinced that there was a definite need for a new type of Weaning Food and they have now developed one that is nutritious, easy to prepare, free from any risk of food infection and within reach of all purses.

This new product is called Bovril Brand Triturated Beef & Vegetable Weaning Food. It was developed after considerable research, in consultation with several paediatric specialists. Although only recently introduced, it is already widely accepted by doctors and clinics.

The Weaning Food is manufactured in four flavours, in cube form; it has a basis of dried mashed potato powder, with added powdered lean beef, beef extract, dried distilled yeast, bone calcium phosphate and iron ammonium citrate. It can be prepared quickly in the form of a digestible purée, by the addition of boiling water to a crushed cube.



BOVRIL BRAND
Triturated Beef & Vegetable

Weaning Food

For infants from 4 months to 2 years of age

THE WARNING OF THE WEDDING RING

If an expectant mother complains that her wedding ring is becoming uncomfortably tight, there is good reason for suspecting occult oedema—with its attendant danger of eclampsia. Careful attention to weight-increase provides a surer means of its detection.

By restricting weight increase to 8-lb. during the 20th to 26th weeks of pregnancy, the risk of eclampsia can be eliminated. Nor is this difficult: safe, sustaining, non-fattening diets are easily prepared with CASILAN. Its protein content is 90% . . . its

sodium content is under 0.1%. Flavourless and as fine as milk powder, CASILAN blends with almost any food your patient fancies or you permit.



WHOLE PROTEIN In 8-oz. and 40 oz. containers
Special terms to Welfare Authorities

GLAXO LABORATORIES LTD., GREENFORD, MIDDLESEX BYRON 3434

a mineral-free combined

Simultaneous immunization of children against whooping-cough and diphtheria is now widely practised, and reports from various parts of the world have suggested that during the poliomyelitis season it is advisable to avoid a mineral carrier. Pertussis Vaccine and Purified Diphtheria Toxoid are now supplied in combination, in buffered saline, without a mineral carrier.

Diphtheria-Pertussis Prophylactic* is prepared in the Wright-Fleming Institute of Microbiology,
St. Mary's Hospital, London, W.2.

* Distinguishing mark 'W.D.P.' (in red letters).

Sole Agents:

PARKE, DAVIS & COMPANY, LIMITED. Inc. U.S.A.

HOUNSLOW, MIDDLESEX Telephone: Hounslow 2361



w hooping-cough and
diphtheria prophylactic

In sets of 3 x 1 c.c. doses and in 10 c.c. vials.

(Each 1 c.c. contains 30 L.f. units
purified Diphtheria Toxoid (F.T.)
with 10,000 millions *H. pertussis*.)



PUBLIC HEALTH

SOCIETY OF MEDICAL OFFICERS OF HEALTH

Telephone: EUSTON 3923

TAVISTOCK HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1

Telegrams: Epidauros, Westcent

No. 1. Vol. LXVI

OCTOBER, 1952

CONTENTS

EDITORIAL

The President's Address	1
Peptic Ulcer	1

SPECIAL ARTICLES

The Changing Face of Paediatrics. By E. Hinden, M.A., M.D., M.R.C.P.	2
Weil's Disease—Occupational Aspects. By A. B. Semple, M.D., D.P.H.	3
The Leicester Home Help Service. By Mrs. P. E. Steed	4
Epidemiology and Aetiology of Carcinoma of the Lung. By Percy Stocks, C.M.G., M.A., M.D., D.P.H., and Richard Dol, M.D., M.R.C.P.	5

CORRESPONDENCE

The Validity of Evidence of Cancer Control (N. E. McKinnon)	7
---	---

OBITUARY

C. E. Tangye, C.B.E., F.R.C.P., M.D., D.P.H.	1
--	---

PAGE

BOOK REVIEWS

Milk: Production and Control (W. Clunie Harvey and H. Hill)	11
Information Digest (Central Council for Health Education)	11

SOCIETY OF MEDICAL OFFICERS OF HEALTH

Notices

Annual Dinner	9
---------------	---

Ordinary Meeting	9
Maternity and Child Welfare Group—Course on Children's Psychological Development	9

Reports

East Anglian Branch	9
East Midland Branch	9
Home Counties Branch	9
Mid and Border Branch	10
Northern Branch	10
North Western Branch	10
West of England Branch	10
County District Group	11

EDITORIAL

The President's Address

Dr. Andrew Topping's address, following his installation by Dr. W. G. Clark as President of the Society on September 17th, will be published in full in the November issue. Meantime, the summaries which have appeared in the medical weekly Press will have conveyed that this was an address which ranged from the under-valuation of prevention and the over-emphasis on curative medicine in this land of the National Health Service to the fundamental questions of the world's future well-being or decline. It was a side of Dr. Topping that may have come as a surprise to those who were unaware of his past career, first in public health in Britain, with distinguished service at Rochdale and in London, then in international relief and rehabilitation as director of the European office of U.N.R.R.A., at the Ministry of Health in the planning stage of the National Health Service, and the chair of social and preventive medicine at Manchester, and finally, dean of the premier school of public health in the Commonwealth. He has never failed to give us fresh confidence in the value of our work and our beliefs, and this presidential address was no exception.

We trust that the very well attended meeting in the Lecture Theatre of the London School of Hygiene and Tropical Medicine, followed by a sherry party, will set a precedent for future installations. The next occasion on which the President and Council hope for a large gathering of members is that of the Annual Dinner on October 23rd, when the Minister of Health (Mr. Ian Macleod) will meet the corporate Public Health Service for the first time. Details are given in a notice on page 9.

Peptic Ulcer

Sir Arthur Porritt, in "A Gastric Gossip," an address to the Hunterian Society last year,* opens our eyes to the fact that we on the preventive side have done little for the three major group diseases of the present time. Of the three groups—cardio-vascular, cancer and peptic ulcer, the last is the least unpromising from our point of view; it is the least fatal, the earliest in life to start, and that which shows greatest change from past ages.

The so-called psychosomatic diseases are peculiar to man; they cannot be reproduced in the laboratory. Their

lesions can be, there are many ways in which stomach ulcers can be given to animals, but these do not produce what in clinical medicine we call peptic ulcer. So if we are to do anything to prevent this miserable infliction it must be based on epidemiology, using that word in its modern wide sense, unless changes in our civilisation lead to its recession as they led to its progression in the past century. Doubtless it existed in the past, but we heard little of it until 100 years ago and not very much until the present century. Sixty years ago, gastric ulcer in young females was one of the commonest hospital diseases. This form is now extinct and it is very doubtful if it had any real connection with the peptic ulcer of the present day. Its epidemiology and symptomatology were wholly different. Except as a rare sequel to burns, duodenal ulcer was scarcely mentioned by the Victorian physicians. Peptic ulcer is mainly a disease of the prime of life, so its increase in recent years is not connected with the increasing age of the population except that as fewer persons die in infancy, more live into the age when peptic ulcer is liable to occur. No race, class or occupation is exempt, but there is some evidence that it is most frequent in middle-class professionals in Western Europe and North America. This is a matter on which we require more information. The aetiology of peptic ulcer as given in textbooks and as generally current is not enlightening; the alleged causes are common to a whole host of chronic diseases and to great numbers of persons who are quite healthy. Sir Arthur mentioned the "ulcer prone," but he cannot tell us how the ulcer prone can be recognised, what the proneness is due to, or give us any hint on which prevention could be based. Yet he knows everything that is known about peptic ulcer! Cannot we do something to increase that knowledge?

We now have the records of millions of persons examined in babyhood and school ages. The offices of every local authority have vaults and attics full of these records. We make no use of them, yet they could be of great value for research into the early history of chronic disease. Any school medical officer could turn up the actual records of 10,000 children examined when they were aged 12 to 14 years. Probably none at that time showed any signs of peptic ulcer, or indeed of any psychosomatic disorder; yet nearly 10 per cent. of them will have become sufferers in later life. Comparing the past records of those who fall with those who do not, it is quite likely that we may find differences between the two groups which are significant and which give us a key to what developed subsequently.

* Abridged in *British Medical Journal* (July 19th, 1952). 2.
107.

THE CHANGING FACE OF PAEDIATRICS*

By E. HINDEN, M.A., M.D., M.R.C.P.,

*Paediatrician to Whipps Cross Hospital,
Consultant Paediatrician to the Education Committee,
County Borough of West Ham*

I feel that a signal honour has been done me, and all paediatricians, that Medical Officers of Health have asked a children's doctor to address them. No one questions that the recent great advances in Child Health have been achieved by the preventive services, and these are very largely in the hands of the M.O.H. The efforts of the paediatrician in salvaging individuals who have been hurt are puny in comparison with the work of the M.O.H., who maintains legions in good health. However, through my association with the School Health Services of my neighbourhood, I may perhaps reflect a little of the M.O.H.'s lustre.

Paediatrics covers a very big field, and a man must show his qualifications ere he discuss it, lest he be found foolhardy. I am indeed fortunate in the range of my work. Based on a Children's Department of a general hospital, I also visit Maternity and Fever hospitals. Through the goodwill of M.O.H.s, I am closely associated with maternity and child welfare clinics, with school clinics and with special schools. In this way I am privileged to view the whole spectrum of Child Health, from birth to leaving school. It has been a fascinating spectacle to watch how the intensity of the "colours" of this spectrum has changed, different aspects of Child Health waxing and waning in importance with the passing years.

The first of these changes has been in Infant Mortality—both grossly in absolute numbers, and in the relative importance of different causes of death. In 1841 the rate was 153 per thousand; 70 years later it was still 130, but another 40 years and it was down (in 1950) to 32; 15 years ago, in West Ham, it was 70, but in 1950 it has dropped to 27·7. When Thomas Farr first published his "Bills of Mortality," three important causes of Infant Mortality were "Teething, Convulsions, Worms." Two of these are not even mentioned nowadays. The great killers in those days were the infections, but their reign of terror is over; now prematurity and congenital deformities are the important enemies. In 1939, out of a total mortality rate of 50·57, prematurity accounted for 14·88, congenital deformities for 6·09. In 1949 the figures are: 32·37 total, prematurity 6·09, congenital deformities 4·57, and these are by far the biggest individual items. It is reassuring to record that the death-rate for prematures has been halved in that 10 years, although I am not aware that prematurity itself is less. This seems to be a real improvement in the handling of these delicate creatures. But it is worth pointing out that one important instrument in preserving prematures—the oxygen tent—seems to be the cause of the terrifying increase in blindness of very small prematures which has been noticed in the past few years. Congenital deformities are being mitigated by the art and craft of surgery. The intestine, the heart, and even the nervous system, have proved amenable to correction, and many babies are now saved who formerly would have perished.

There have been equally profound changes in the morbidity of older children. The metabolic diseases—rickets, scurvy—have become rarities. Tuberculosis declines in importance each year; public health measures are largely responsible for this, though streptomycin may claim a share. We may reasonably hope that BCG vaccine will greatly reduce even the present low morbidity. Rheumatic fever, too, is no longer the scourge it was. Within the past five years I have seen a great diminution in this disease at Whippes Cross. In 1948 there were 49 patients with five deaths; in 1951, 24 patients with one death; and in the first half of this year, but five patients and no death. It is not certain why this has happened. I feel myself that a diminution in virulence of the haemolytic strepto-

coccus (witness the decadence of scarlet fever) and an improvement in general health and nutrition, are the most likely causes.

The eclipse of the bacterial infections has overtaken the viruses too. Measles, rubella, chicken-pox, mumps—their mortality is negligible, and (in childhood) their morbidity trifling, in spite of their all-but-universal incidence. Has not the time come to reconsider our attitude to these infections? In an urban community total escape is well-nigh impossible, and our methods of "control" can only shift the incidence from childhood to later on in life, when the diseases are much more unpleasant and—as with mumps in men and rubella in pregnant women—much more dangerous. I think that isolation of patients and quarantine of contacts wastes a lot of time, confers no permanent protection, but merely postpones trouble to a much more inconvenient moment. Would it not be far better to ignore their infectivity altogether, and to treat sufferers as one does all other patients? Keep them snug in bed when they are ill, but when they are clinically well, turn them loose. School absence would be greatly shortened, school closure avoided altogether, and the adult population saved much sickness. A house physician of mine at Whippes Cross, who had been protected in her childhood from infection, caught both chicken-pox and mumps in her six months of duty, to her great personal discomfort and detriment. The menacing exception to this argument is poliomyelitis, whose ravages seem growing year by year.

With the falling-off of infections, violence as a cause of morbidity (and mortality) becomes more important. Scalds are one of the most frequent serious causes of admission to hospital.

In general, the child population of the country is physically healthier than ever before. I have seen a letter written in 1915 by the then Medical Superintendent to his managing committee, stating that he had 275 children in hospital (one-third of his community) scattered widely in all his wards, and that it was quite impossible to look after them adequately. The hospital is the same size to-day, but the number of children's beds is a third of what it was then, and in summer the beds are not filled. With this falling-off in physical disease we are becoming more and more aware of children's mental and spiritual states, and behaviour disorders have replaced "teething, worms, convulsions" as the biggest headache of our time. Problems of feeding, of excretory control, of speech, of social behaviour—it is these which fill our out-patient clinics to-day, and very difficult they are to treat. And not only our out-patients; last year enuresis was the commonest single cause for admission to my wards at Whippes Cross, where my senior Registrar, Dr. Poulton, has shown that usually a disordered renal physiology underlies it.

Akin to these conditions is juvenile delinquency, also on the increase. Child Guidance, founded and fostered to deal with these particular problems, has not as yet shown itself equal to the task. It can plead many reasons for this failure; its own youth and inexperience; the lack of trained personnel; the length of time taken for treatment. But the main reason for its poor success is inherent in its very nature. The usual cause for child straying from the path of acceptable conduct is some disharmony in the household—either between parents and child, or between parents themselves. Often there is some crack in the parent's own personality, the scar, perhaps, of his own unhappy childhood. And this very flaw, which called the problem into being, also makes it hard to resolve. The parent has a blind spot as to where he (usually she) has gone wrong; cannot accept the proffered advice, and soon stops attending. "Case closed for lack of co-operation"—that is an all-too-common end. We must remember, however, that most mothers are well able to care for their children, and the majority of our young people grow up clean and straight, in mind as in limb. A well-known child psychiatrist, Dr. Leo Kanner, has recently produced a book, "In praise of mothers, or how to bring up children in spite of the psychologists," to remind us in whose hands the training of young children properly resides.

* Based on an address delivered to the Home Counties Branch, Society of Medical Officers of Health, London, July 11th, 1952.

In this field there have been two fundamental contributions to knowledge. The first is due to the careful observations of Dr. Arnold Gesell and his school. He has shown us that the intellectual and spiritual growth of a child follows a shape no less precise than that of its physical development, so that at every point along the path to maturity there is a different pattern of *normal* behaviour ; and it is rare indeed for this pattern to resemble adult behaviour. At different stages in its growth it is normal for the child to lie, to show temper tantrums, to be lazy or cruel. Prof. Alan Moncrieff has already taught us that "all children are delinquent, but only some are found out." Often great unhappiness descends on families, because parents do not realise that their child's "wickedness" is normal behaviour for his age ; and that were he to behave with that sweet reason and adult consideration they themselves would show in his place, he would indeed be a monster ! The second great contribution to Child Guidance has been made by Dr. John Bowlby, in showing the pre-eminence of maternal care and affection in the full development of the child, particularly in his first two years. There is no substitute for this material ; it is priceless and irreplaceable, and it may well be that the big development of paediatrics, as yet under the horizon, will be to ensure good "mothering" for all children, as the greatest prophylactic against mental upset. This work shows how we may contrive to break the vicious circle ; maladjusted children growing up into maladjusted parents, and breeding yet more problem children in their turn. All the resources of social medicine must be mobilised to make it easy for the "difficult" mother to love and cherish her child. Bowlby has also issued a solemn warning to paediatricians, that taking a young child away from his mother and his home, into even the most perfect institution or hospital, inflicts a severe wound on his budding sense of security in a hostile world. The documented evidence he has accumulated—that even an indifferent mother is far better than no mother—gives chapter and verse to Sir James Spence's aphorism, that when we find an inefficient mother and a harassed household, "we relieve her of her child, when we should relieve her of her chores."

These changes in our medical approach to the child do but reflect changes in the way our culture looks upon him. At first—and not so long ago either—the child had no rights. He could be put to work, or starved, or beaten, at his parents' whim. But the last century has seen a revolution in all this. Factory Acts and School Acts have given him status, and public opinion has endowed him with personality. No longer can it be said of a teacher (as was once said of a headmaster of a famous public school) that he knew the posteriors of his pupils better than their faces ! The days of a mass birth-rate, and an equally massive death-rate, have gone. Each child is now a prized entity ; his needs are studied and provided for. The growing awareness of the child as a person in his own right has led to our seeing the need to integrate all the services which look after him. The paediatrician has shared in these changes. No longer does he approach the child with an air of Jovian omnipotence ; he is no longer sure that "doctor knows what's best." The face of paediatrics, as seen by the child, has become quite another visage ; not didactic, but inquiring ; not commanding, but inviting ; above all, no longer imperious, but companionable.

To one other group, also, has the complexion of paediatrics changed—to the general physician. When a specialty is first formed, it is natural for its acolytes to wrap it up in a blanket of mystery ; this nourishes their pride and fattens their pockets. But as facts accumulate, knowledge seeps out of the circle of cognoscenti and gradually spreads among all. This process is hastened by the truly enlightened, who see it as their duty to educate their fellows as well as themselves. All this happened to paediatrics. In the flush of their first enthusiasm, its devotees liked to think that only they could be trusted to care for children. But the missionary zeal of the leaders of the specialty has spread the basic facts of child health far and wide, so that more and

more general practitioners can handle children with confidence and success. To them, paediatrics is no longer a Cabala of esoteric knowledge, it is a storehouse with the doors wide open, and the facts displayed freely on open shelves, so that all may help themselves—and welcome ! In fact, it seems to me that paediatrics as a specialty is a dying subject, the paediatricians themselves having killed it. And if, indeed, they succeed in doing this, their will be the glory of a magnificent achievement : the first re-integration with general medicine of a specialty's garnered wisdom.

WEIL'S DISEASE—OCCUPATIONAL ASPECTS*

By ANDREW B. SEMPLE, M.D., D.P.H.,

Deputy Medical Officer of Health, City of Liverpool

In this paper I propose to indicate briefly the preventive measures against Weil's disease which have been taken in Liverpool and the reasons why they were considered necessary.

Our attention was first directed to the hazard of Weil's disease in persons in contact with sewage when three sewer labourers contracted the disease in the latter months of 1947. No further cases came to our notice till November, 1949, when two further Corporation sewer workers contracted the disease and one of them died. Weil's disease is a scheduled disease under the National Insurance (Industrial Injuries) Act, 1946, and was included in the list of scheduled diseases in 1924. This means that the occurrence of Weil's disease in a workman, provided that the infection arose out of his work, renders him eligible for Industrial Injuries benefit in accordance with the above Act.

It was considered that the Corporation should review the working conditions of sewer men with a view to preventing as far as possible further cases occurring. Since July, 1947, seven cases of Weil's disease have occurred in Corporation workmen—all were sewer labourers, and three of these cases have proved fatal, one in 1949 and two in 1951.

Observations made on the working habits of sewer men showed that there were considerable possibilities for infection. This was especially so in men working on the repair and rebuilding of old sewers and in clearing blocked sewers. Although the men sometimes wore Wellington boots which protected their feet and legs, they frequently got their hands and arms contaminated with sewage and their tools were often soaked with sewage. It was observed that the men disregarded the contamination of their hands and that no proper washing facilities were provided on such jobs, which made personal cleanliness difficult to achieve.

As a result, arrangements were made for adequate washing facilities to be provided on all sewage jobs. Nowadays, on the larger jobs warm water, clean towels and soap are provided and the men are encouraged to use them. On small jobs the men are provided with soap and towels and instructed to get permission from a householder to call on them to wash, especially before taking any food. Sewer rods and other apparatus are cleaned and disinfected after use so that fresh contamination is reduced to a minimum. It has been impressed on the men, and especially upon the District Inspectors who supervise their work, that for the prevention of Weil's disease cleanliness is the main form of personal protection especially before eating or smoking. Also as the *Leptospirae* gain access through cuts and abrasions, the men are advised to have all abrasions and cuts dressed as soon as possible with waterproof adhesive dressings which are readily available in first-aid kits.

We considered the use of certain wet barrier creams, but these were abandoned as useless as they were not effective over broken skin and were thought to give a false sense of security.

Rubber boots are worn on all foul jobs where the feet are liable to get wet, and rubber gloves are provided in

* Paper read to the Fever Hospital Group, Society of M.O.H., at Liverpool, April 18th, 1952.

special instances where contamination is liable to be heavy. Unfortunately, rubber gloves are apt to tear or the sewage may get in at the top of the gauntlet, and they are not considered suitable for use except under specially foul conditions.

General protection of the clothing is given by providing overall suits.

When these steps had been taken, further investigations revealed that from the clinical point of view the true nature of Weil's disease was not diagnosed for several days, as the condition was such a rare one that the true diagnosis did not occur to practitioners, who frequently treated such sufferers as cases of influenza. It was decided to issue to all men in contact with sewage a card giving them some simple instructions on personal hygiene and advising that they should show this card to any doctor attending them for an illness in order to call his attention to the possibility of Weil's disease. To assist doctors who might not be familiar with the symptomatology a brief description of the disease was included on the back of the card and doubtful cases were asked to get into touch with the Public Health Department. The issue of these cards has been much appreciated by both general practitioners and the men.

Nevertheless, the main preventive measure is to prevent sewage from being infected with the *Leptospira* and to this end an intensive campaign of rat extermination is being planned. It is essential that rat destruction in the sewers should go on simultaneously with rodent control operations on the surface. In the last six months of 1951 23 rats caught in various parts of the city were examined for *L. icterohaemorrhagica* and the organism was isolated in eight instances, i.e., about 38% of rats in the city are carriers of the organism, which is in accord with findings in other places.

Under the Prevention of Damage by Pests Act, 1949, extensive powers are given to local authorities in matters of rodent control and it is hoped to make full use of these powers. Arrangements have been made to carry out intensive rat extermination in an area where the City Engineer will shortly afterwards be carrying out a large sewage job.

It is hoped by efficient co-ordinated rodent control together with good personal hygiene among the sewer workers and early diagnosis to radically reduce the morbidity and mortality from Weil's disease in Liverpool.

OBITUARY

Claud Edward Tangye, C.B.E., M.D. (BIRM.), D.P.H.

The recent death of Dr. C. E. Tangye, at his place of retirement in St. Mawes, Cornwall, in his 74th year, has taken away one of the most influential County Medical Officers of Health of his generation. One of a well-known Birmingham family, he started a career as schoolmaster, then turned to medicine and qualified in Birmingham in 1905, graduated M.D., with a gold medal, in 1907, took the D.P.H. in 1909, and in the same year became M.O.H. for Warwickshire combined districts. In 1919 he was appointed County Medical Officer of Health for Wiltshire, where he was to spend the remaining 26 years of his career.

He built up a good organisation of public health in his county, initiating a pioneer orthopaedic scheme. He was a leading member and one-time President of the Association of County Medical Officers of Health and adviser to the County Councils Association. In 1928 he served as a member of the important Departmental Committee on Maternal Mortality and Morbidity. He also took a prominent part in the B.M.A., being president of the Wiltshire Branch in 1927. He was awarded a C.B.E. for his services to public health in 1944.

He joined the Society in 1909 and was elected a Life Fellow on his retirement. His wife predeceased him in 1948.

THE LEICESTER HOME HELP SERVICE*

By Mrs. P. E. STEED,
Home Help Organiser, City of Leicester

I feel honoured, but a little apprehensive, in addressing so distinguished and so preponderantly masculine a company on a subject so homely as the Home Help Service. But by now, I think, after some years of doubt and disputation, and out of a tangle of prejudices and stigmas attached to the domestic nature of her calling, the Home Help is beginning to emerge, not as a sort of glorified "Mrs. Mop," but as a creature of many parts, able to take her small but significant corner in the field of social medicine. It is perhaps indicative of this new trend of thought that you are giving her this space in your discussions to-day.

As a permissive, not a compulsory, service, the Home Help Service is open to a wide variety of interpretations. My part is to present to you one of these interpretations, that of the Local Authority in the County Borough of Leicester, in the hope that it may provide a basis for your discussions or, at least, a target for your criticism. I should explain that I am reading my account in the form of a paper, having presumed to suppose that you would prefer a considered statement rather than a more direct method which would inevitably be coloured by your response to my approach to the subject.

I have brought with me three members of the Service —Mrs. Dickens, Mrs. Wilson and Miss Pickles—who will be very happy to show you their uniforms and answer any questions you may like to put to them.

I propose to divide my account into three parts : the Home Helps, the Homes to be Helped, and the fitting of one to the other in the Home Help Service.

First, the Home Helps. We have, at present, an establishment of 250 full-time Home Helps. We reached this establishment at the end of the last financial year and although it does not represent the target that has been suggested, of one per thousand of our population, we are running the Service at this figure for an experimental year in order to discover how far, over a period, supply is short of demand. The ascertainment of the point of establishment when supply and demand would be balanced is by no means easy. My experience has shown that the Service tends to grow like a snowball. One good Home Help added to our staff does not represent one measure on the side of supply. Her attendance in a particular home will often be followed up by several requests for help from homes in the same street, all perfectly genuine when investigated but withheld until then through prejudice or ignorance ; all—if they are to be served—weighting the already over-weighted demand.

Recruitment is easy. We have, at present, a long waiting list of suitable candidates. By suitable, I mean women of integrity (this we discover by careful attention to references and background) with a good social sense and high standards of homecraft. When they have been selected they are required to wait until the next Preparation Course, perhaps two or three months. This is itself a test of their determination to be considered for the Service.

Leicester County Borough is, I believe, the only Local Authority which has held to the principle, since the inception of the Service, that no Home Help should be enrolled until she has attended a course and satisfied the tutors that she is a suitable person in every way to be sent into the homes of the city. This principle has been accepted and developed in all the more progressive European countries. Our course in Leicester, which has aroused some interest nationally and internationally, is designed not to instruct novices in the very skilled work of home-making and home-craft or the social skills which must accompany it, but to prepare women who have already attained these skills for the emergencies and vicissitudes with which they will have to deal in their work as Home Helps. The courses are arranged by the Education Department as part of

* Paper read to the County Borough M.O.H. Group, at Leicester, Sunday, June 29th, 1952.

Women's Further Education. The cost of providing a tutor in domestic subjects and suitable premises is borne by the Education Authority.

During the two weeks of the course the candidate receives guidance from this tutor in the use of all kinds of domestic equipment, in budgeting and catering for families of different sizes and different income groups, in the preparation of invalid dishes and special diets, in infant feeding and in any branch of homecraft in which she herself asks for instruction. In addition, she attends lectures and demonstrations given by senior Health Visitors in home-nursing, child care and the protection of herself and other members of the family when she is attending homes in which there is a patient suffering from an infectious disease, particularly tuberculosis. On two mornings she accompanies Health Visitors and Midwives on home visits. Talks and discussion groups introduce her to the social aspect of her work. Visual aids in the form of films are used. During these weeks she is given a medical examination, Mantoux Test, and chest x-ray. At the end of the course comes the test-day, and if she then satisfies her tutors she is finally presented with her badge of office by the Chairman of the Health Committee. During the course she receives a subsistence allowance of £2 10s. 0d. per week.

As a Home Help she has a guaranteed 44-hour working week. A few part-time Home Helps were enrolled in the early days of the Service but we have for some years only accepted those who are prepared to work full-time. This principle calls for greater skill on the part of the organisers in the allocation of work but has great advantages financially to the Local Authority in keeping National Insurance costs to the minimum and to the Service in the preservation of a disciplined continuity of work. Our Home Helps are eligible for superannuation and for sick pay and holidays in accordance with the J.I.C. agreement covering manual workers. Their gross pay is £4 17s. 8d. per week. Uniform is provided after a probationary period of three months' service, an outdoor coat and hat, two indoor dresses, a white overall and a coarse apron.

The city is divided into five districts, each with a branch office and an Assistant Organiser in charge of 50 Home Helps, who report to her for duty. We have a Welfare Committee, consisting of one representative of each branch, which meets periodically (after hours) to consult with Dr. Humphreys and the organising staff, iron out any small discontents before they become major problems, make suggestions for the improvement of the Service and arrange outings and social gatherings. In addition, a quarterly staff meeting of all Home Helps and organisers is held on a Saturday afternoon. I would have liked to enlarge on this, the personnel management aspect of our work, one which I feel is too often neglected in Local Government.

In deciding the homes to be helped, we cover those emergencies listed in Section 29 of the National Health Service Act. We guarantee to the mother having her baby at home two weeks' help at the time of her confinement, or longer if recommended by her doctor or midwife. In sudden illness or domestic emergency we are able, with our present establishment, to provide help within a few hours of receiving the application. For long-term help the applicant may have to wait several days. For help which, on medical evidence, is desirable but not essential, the applicant is informed that it can be supplied if he or she will accept it as and when it is available.

The full charge of the Service to the householder (this includes administrative and overhead costs) is 3s. 6d. per hour. Applicants are assessed according to their means. The scales recommended by the A.M.C. are used in assessment but the assessable income is arrived at by giving to each member of the family helped an appropriate personal allowance at the rates laid down in the National Assistance Schedule of Allowances, by adding to this the cost of rent and rates and by deducting this sum from the income of the family. This income includes appropriate contributions from earning members of the family who are held to benefit from the services of the Home Help. The weekly

assessment is fractionalised according to the number of half-days in each week on which the Home Help attends. We who apply this new method of assessment, a modification of the A.M.C. recommendations, find that it is acceptable to most householders and by following the N.A.B. allowances is taking some account of cost of living fluctuations.

The work of the Service and of the Home Help within the Service is, I find, threefold; it preserves, it repairs, it creates. If we may be allowed to regard the Home as our patient and our work as social medicine, this threefold work of the Home Help can be illustrated.

The Home Help arrives in the healthy home to find everything in good order, larder well provisioned, furniture and equipment adequate, the family a little disturbed by whatever crisis has overtaken them but used to an orderly life. It is the work of the Home Help on these occasions to preserve that good order until the real home-maker is able to take over again, to provide a peaceful background in which the patient can recover or the young mother have her baby without anxiety. But when the home is sick, the house dirty and neglected, the members of the family out of sorts with each other and with the world, the household finances in disorder, equipment, food and goodwill lacking, then the Home Help must put out all her skills, domestic and social, to repair the damage already done and to create out of the chaos something which will give stability to the older members and security to the younger members of the family. These are the so-called "problem" homes. I prefer to call them sick homes and I believe that the Home Help, if her status and skill are given recognition, will be the key social worker in dealing with these homes.

The Service is costly. In Leicester during the last financial year the gross expenditure on the Service was approximately £57,000. Of this, about £7,000 was recovered in charges to householders, leaving a net expenditure of approximately £50,000 and a rate-borne expenditure of £25,000. This, I submit, was money well spent. We estimate that, as a result of the work of the Service in 1951, 72 beds were freed in sanatoria, 800 in maternity hospitals, and in general hospitals 108 beds for short-term and 945 for long-term sickness. Last week about 1,000 people in Leicester received some benefit from the Service whether as sick persons or as other members of the family. It is difficult to envisage the full extent of the influence which a good Home Help Service may have in the homes of our cities. I believe that when the Home Help emerges, as she has done in some of the Scandinavian countries, as a professional social worker, she will prove as vital to the home life of our country as the Health Visitor, the Home Nurse or the Midwife in their very different spheres.

EPIDEMIOLOGY AND AETIOLOGY OF CARCINOMA OF THE LUNG

A meeting of the Metropolitan Branch was held at B.M.A. House on Friday, May 9th, 1952, at 5.30 p.m. The President (Dr. W. H. Bradley) was in the chair and there was a large attendance of members of the Metropolitan Branch and, by invitation, of the Home Counties and other Branches, and several visitors.

The occasion of the meeting was a symposium arranged by the President on the epidemiology and other aspects of carcinoma of the lungs, the opening speakers being Dr. Percy Stocks (formerly Chief Medical Statistician to the General Register Office), Dr. Peter Kerley (Director of the X-ray Department, Westminster Hospital) and Dr. Richard Doll (of the Statistical Research Unit of the Medical Research Council). Abridgments of Drs. Stocks' and Doll's papers follow overleaf.

Dr. Percy Stocks, formerly Chief Medical Statistician to the General Register Office, began by welcoming the interest now being shown by M.O.H.s in the epidemiology of lung cancer, by which he meant carcinoma or other malignant neoplasm of the bronchus, lung and pleura. In his references to mortality whatever rate was used had been standardised for age.

The idea that irritants, poisons or deficiencies might be factors in the aetiology of cancer and that other features of an environment might neutralise their effect was hardly a new one; there had been fragmentary studies in the epidemiology of the disease even in the 19th century. The G.R.O. had worked patiently upon the occupational aspects at successive censuses with increasing detail as death certification of primary cancer sites improved, and there were now international conferences on the epidemiology of this disease.

Dr. Stocks said that 15 years ago he had called attention to the distribution of cancer mortality by counties in England and Wales. In his 1947 G.R.O. monograph he had pointed out the inverse correlation between the amount of sunshine recorded in 20 large towns and their lung cancer mortalities, and concluded that either smokiness of atmosphere was a factor in producing lung cancer or that sunshine prevented its incidence. These studies had been based on the 1921-30 figures. Between 1930 and 1946 the rates had risen steadily and surprisingly. The M.R.C. had called a conference which had led to the study by Bradford Hill and Doll of the tobacco-smoking histories of lung cancer patients and controls. The result had proved beyond doubt that smoking was an important factor, but not that it was the only factor in causation of lung cancer. In the four years 1946-49 the lung cancer deaths of males averaged 8,183 annually, and of females 1,774. In 1950 male deaths exceeded 10,250 and those of females were nearly 2,000. The numbers showed no sign of levelling out and were increasing by about 8% annually during the period 1946-49. Applying the male death-rates at each age period in the decade 1921-30 to the corresponding populations at the end of 1947, the calculated annual deaths of males in 1946-49 would have been 812, so male mortality increased tenfold in the 22 years. At ages 35-45 the increase was sixfold and at 55-75 it was elevenfold.

One could only surmise how much of this enormous increase had been due to more complete detection and how much to higher incidence. Two maps of London, for 1921-30 and for 1946-49, which he had made showing standardised mortality ratios for each Metropolitan borough had an interesting difference. For London County male mortality increased eightfold between the two periods and was now about 60% greater than for the whole country and two and a half times the rate for rural districts. The 1921-30 map showed two high mortality areas, one in Bermondsey, Stepney, Bethnal Green, Hackney and Stoke Newington, the other in Hampstead, St. Marylebone, Paddington, Westminster, Chelsea and Fulham, an area with the best diagnostic facilities at that time. In 1946-49 male mortality was highest in Bermondsey, Stepney, Bethnal Green, Shoreditch and Finsbury, and above average in five adjacent boroughs, as well as in Battersea and Hammersmith. But in the Western area from Hampstead to Fulham mortality was below average, in his opinion owing to the disappearance of the diagnostic differential within London so that the map now indicated difference of incidence only. The distribution was obviously correlated with social class and density per room indices but that did not explain it. We could hardly suppose that people in N.E. London smoked 50% more tobacco than those in S.W.

A similar study of the county boroughs over the same period showed the highest mortalities in towns in large conurbations, whence there was a descending order to the small towns. This relation with size of continuing urban area had led him to a further study of both London and county boroughs for the period 1946-49, in descending order of the total occupied dwellings and population densities per acre, because the amount of atmospheric pollution by domestic smoke must be a function of the total area over which dwellings were spread, of the density of dwellings and the meteorological behaviour of the air.

If lung cancer was caused in part by atmospheric pollution by smoke from domestic chimneys, we could expect the rate to increase as the total number of inhabited dwellings increased, and it would be correlated also with the density per acre. The result of this study was to show that the large built-up areas (over 200,000 dwellings) had male mortality figures from 132 to 162, whilst the aggregates of smaller areas with total dwellings ranging from 125,000 down to 20,000 or less had mortalities decreasing from 135 to 89. Apart from certain exceptions (such as seaside towns with

many residents who had worked in large cities) the lung cancer mortality tended to increase with total number of chimneys until the dwellings exceeded 100,000, when some other factor, perhaps high density per acre, must account for the very high rates in London, Manchester and Merseyside.

The facts fitted in with the hypothesis that atmospheric pollution by smoke was an important factor on which tobacco smoking was superimposed. The carcinogenic substance, whatever it was, might be common to both kinds of smoke, or they might contain different irritants. Dr. Stocks then showed how the prevailing winds recorded in London would have the effect of shifting the smoke density some distance from the centre in an E.N.E. direction; that was what the map for lung cancer mortality showed also. There was also a positive correlation of 0.37 with density per acre in the Metropolitan boroughs, which were affected by their own smoke as well as by that blown from other parts. If 90% of lung cancer in that area was due to tobacco alone, the hypothesis of atmospheric pollution could not be squared with the M.R.C. figures, but he thought that the figures were compatible with the theory that the effects of tobacco and atmospheric pollution were additive. The total contribution of tobacco smoking to lung cancer incidence could not be deduced from the relative frequencies found amongst non-smokers and smokers of 10, 20, 30 or 40 cigarettes a day in Greater London alone. Similar studies would be necessary, and had already started, amongst residents of rural areas where it might be found that smoking did not begin to show an appreciable relation with lung cancer incidence until the daily number of cigarettes was at a higher level than appeared to be the case in London.

Although statistics themselves could not establish causation, they could start what biochemistry and pathology would finish, and they might even make sense out of a chaos of isolated findings by other research workers. Dr. Stocks thought that might happen sooner for lung carcinoma than for any other form of cancer.

In the course of the discussion Dr. Stocks said that his full paper, with map and tables of statistics, would be published in the *British Journal of Cancer*.

Dr. Richard Doll, member of the Statistical Research Unit of the Medical Research Council, said that cancer of the lung had become, in recent years, one of the most important causes of death and its prevention was one of the more urgent problems facing medical scientists. The number of deaths attributed to cancer of the lung increased annually. If even part of the increase was real we could be optimistic about the possibility of preventing a proportion of the cases; for a true increase in incidence must indicate that some environmental change had contributed to the development of the disease and it might, therefore, be hoped that the trend could be reversed by reversing the change in the environment.

A number of clues were available to indicate what the environmental change, or changes, might be. For example, the mortality from cancer of the lung was reported to be grossly different in different countries. In Britain, it appeared to be the highest in the world; in Austria, Holland, Switzerland and some other countries of Western Europe and in the U.S.A. it was high, in Norway relatively lower, in Iceland very low. Among the primitive communities of Africa and in parts of Asia, necropsy studies indicated that the disease was extremely rare. Again, whenever the distinction had been made between town and country dwellers, the disease had been recorded as being more common among the townsmen. Whether these differences were spurious or real was open to argument, but in some instances (for example, the difference between Britain and Iceland) the evidence that they were real was strong. These observations all pointed to a number of factors associated with modern industrialisation—atmospheric pollution by smoke, by motor fumes and by the dust from tarred roads and the smoking of cigarettes—but they failed to differentiate between the roles played by each of them individually.

A different type of evidence was provided by the sex ratio which, in countries where the disease is common, was invariably far from equality. Widely different estimates of the sex ratio were obtained from different data but in Britain a reasonable estimate was probably of the order of six to one.

Some cases were known to be due to exposure to specific occupational hazards. The most firmly established occupational cases were those occurring after work in the mines of Jachymov (or Schneeberg) in Czechoslovakia and Germany. In Britain, specific occupational risks were known to occur in the handling of asbestos fibre, in a specific nickel refinery and in gasworks. Gloyne had shown that primary cancer of the lung was twice as common in the lungs of men dying with asbestos as in the lungs of men dying with other forms of pneumoconiosis; the

great frequency of the disease among men employed in the nickel refinery had been pointed out by Amor and by the Chief Inspector of Factories and cancer of the lung occurring among men employed at the refinery had now been scheduled as an industrial disease; Kennaway and Kennaway reviewed the death certificates of all persons dying of lung cancer between 1921 and 1938 and observed a consistently high incidence among all forms of gasworkers and this had now been confirmed by Doll in a study of the causes of death among pensioners of a London gas company. A risk was probably also associated with the manufacture of inorganic arsenics; the most suggestive evidence of this had been produced by Hill and Fanning in a study of the causes of death of the employees in a factory making arsenious oxide; the number of deaths attributed to the disease was, however, small and the case must, as yet, be considered unproven. In Germany and the U.S.A. the production of chromates had been suspected of being dangerous and convincing evidence that there was, in fact, a considerable risk involved in the manufacture of chromates in the U.S.A. had been adduced by Machle and Gregorius and by Baetjer; according to the former, the risk was as much as 20 times that run by the general population. The evidence from British chromate factories was still inconclusive. Other occupations suspected of providing special lung-cancer hazards were metal-grinding and working with any form of hot metal.

The carcinogenic agents concerned were believed to be radon in the case of the Jachymov mines and benzo(a)pyrene in gasworks; arsenic might possibly be a common carcinogenic factor in the arsenic, nickel and chrome industries. All the occupations referred to could not, however, account for more than a very small proportion of the deaths actually attributed to the disease and some more general factor must be looked for to account for its widespread incidence and for the recorded increase in the number of deaths attributed to it.

The high incidence observed among gasworkers suggested that residence near a gasworks or the use of gas fires in the home might be such a factor; neither had, however, proved to be of any significance. The presence of known carcinogens in the tar used for road surfacing and in the exhaust pipes of motor cars indicated two other possible sources, but their importance was disconcerted by the observation that men employed in occupations which exposed them particularly closely to such material had no higher incidence of the disease than did other urban residents.

A possible factor of widespread distribution was smoking. A number of clinical investigations had been carried out in the last 15 years to determine whether there was any association between the habit and the development of the disease, and all had agreed in finding a lower proportion of non-smokers and a higher proportion of heavy smokers among the lung-cancer patients than among the other patients with whom they were compared. In Britain, Bradford Hill and Doll had reported the results obtained from the examination of 709 patients with lung-cancer and 709 other patients chosen to be of the same sex and age as the lung-cancer patients and in the same hospitals at approximately the same time. The lung-cancer patients were seen in 20 different London hospitals but they were all interviewed by one of four almoners who were working full-time in research; the same almoners also selected and interviewed the corresponding control patients. A non-smoker was defined as a person who had never smoked as much as one cigarette a day for as long as one year. The results revealed that only two out of 649 male lung-cancer patients were non-smokers (0.3%) against 27 out of the 649 male control patients (4.2%) and 19 out of 60 female lung-cancer patients were non-smokers (31.7%) against 32 out of the 60 female control patients (53.3%). Moreover, when the smokers were subdivided according to the amount smoked it was found, in both sexes, that the ratio between the proportions of lung-cancer and control patients who smoked the same amount of tobacco increased *pari passu* with the amount smoked.

On the assumption that the lung-cancer patients interviewed who lived in Greater London were typical, with regard to their smoking habits, of all the patients dying of the disease in Greater London and that the patients with other diseases who were interviewed were also typical of the inhabitants of Greater London generally, it was possible to calculate the relative risks of developing lung-cancer for each level of consumption of tobacco in each age group. Between the ages of 45 and 74 it was estimated that the risks of developing the disease when smoking 1 to 4, 5 to 9, 10 to 24, 25 to 49 and 50 or more cigarettes a day were respectively 6, 19, 26, 49 and 65 times as great as the risk run by a non-smoker.

Apart from the amount smoked, it also appeared that there was an association with the age at which smoking was begun, the number of years smoking was continued and the length of time it had been stopped. The last association was the most

marked, and it appeared as if the risk of developing the disease among men who continued to smoke might be something like three times as great as the risk among men who had given up for over 10 years.

A point of some interest was the different proportions of pipe and cigarette smokers in the lung-cancer and control groups. Fewer of the former had confined themselves to smoking pipes and it appeared that there might be a lesser risk with this form of tobacco consumption. It was, however, difficult to be certain as pipe-smokers tended to smoke less than cigarette smokers and this alone might account for the difference—though it did not appear to be adequate to do so entirely.

The finding of an association between one disease group and the amount of tobacco reported to have been smoked did not, of course, necessarily mean that there was a causal relation between smoking and the disease. A number of possible explanations must be considered such as, for example, that there might have been bias in the selection of patients for interview, in the histories given by the patients or in the details recorded by the interviewers. None of these explanations appeared to be valid in relation to some of the more recent investigations and it would seem necessary to conclude that there was a true association between the habit and the disease. The disease certainly could not have caused the habit, formed many years before the first symptom of the disease appeared, and it had not, to his mind, been found possible to postulate any common cause which could give rise to the habit and to the development of the disease 30 to 40 years later. It, therefore, seemed probable that the association did, in fact, imply that smoking was a factor—and an important factor—in the production of lung-cancer.

If such a conclusion was accepted it was of interest to see how far it could account for the observed differences in the incidence of the disease. In general, a causal relationship between smoking and lung-cancer was in accordance with the observation of an increased incidence in recent years, of a greater incidence in men than in women and in townsmen than in countrymen—but it had not been shown to account completely for the actual size of the differences. This might be because our knowledge of the relationship with smoking was incomplete, because the quality of the tobacco was of importance as well as the quantity, because the observed differences were partly spurious or because other factors independent of tobacco (e.g., sex susceptibility) were involved.

Dr. Doll concluded by saying that it was clear that smoking was not the only factor responsible for the production of lung-cancer. No proved carcinogen had as yet been isolated from tobacco smoke and the chain of causation by which smoking contributed to the formation of the disease might be far from simple. An attractive hypothesis, in the present state of ignorance, was that smoking, particularly of cigarettes, might act to produce cancer in conjunction with the benzo(a)pyrene known to contaminate the atmosphere, derived mainly from the soot from domestic fires. Such a hypothesis would accord well with the observations reported by Dr. Stocks.

CORRESPONDENCE

THE VALIDITY OF EVIDENCE OF CANCER CONTROL

To the Editor of PUBLIC HEALTH.

Sir,—Dr. Malcolm Donaldson in PUBLIC HEALTH, July, 1952, page 169, questions the evidence that early treatment does not control breast cancer mortality; he also quotes argument to the contrary. The subject is too large to deal with adequately in correspondence, but some points must be met.

Dr. Donaldson says that precise figures of the shift to early treatment have not been presented, and he implies, therefore, that conclusions drawn without such figures cannot be given credence. It is true that very few precise figures in this regard are available, but the more than 50% increase in the admittedly small proportion consulting their medical advisers allegedly within the first month in Massachusetts and some related data have been briefly mentioned (*Canad. P.H.J.*, 1950, **41**, 231). The data usually presented as showing the extent of the shift refer to the increase in the proportion of Stage I or Stage II cases. As stage is much more an indication of type of tumour than of duration those data do not provide any sound basis for measuring changes in duration; they merely suggest the direction of the shift. However, anyone familiar with conditions in this country (Canada) over the past 30 years or so knows that there have been great changes in the economic status of the people, in transportation facilities, in accessibility and use of medical and particularly of specialist services, in hospitalisation for investigation and care of patients, and in the attitude of the people to investigation and treatment. Over all those years and for even

longer the medical schools have sent out their graduates with a crusading zeal "to get cancer early," and these graduates have not been remiss in applying what they had been taught. There have been, too, changes in diagnostic and therapeutic facilities and techniques. Consideration of these factors, even without figures, leaves little doubt that if such earlier treatment were effectual in reducing mortality, there should have been some decline in the age-specific mortality rates for breast cancer. The persistence of level trends in each and all of the provinces of Canada thus throws grave doubt on the superior efficacy of the earlier treatment in preventing death.

In addition, some provinces have made deliberate and thorough-going efforts to reduce the mortality through early diagnosis and treatment. One province, as noted previously (*C.J.P.H.*, 1950, **46**, 7-14) and as indicated by Drs. Watson and Beresford in the *B.M.J.*, January 12th, 1952, page 107, has had a most aggressive programme with an embarrassingly large response in attendance at clinics, giving, as Drs. Watson and Beresford say, "a marked increase in the percentage of early cases seen in the Government cancer clinics." In another province there was no programme and according to the late Dr. Allan W. Blair, then Director of Cancer Services for the Province of Saskatchewan, in a report of a survey he made for the National Cancer Institute of Canada, no increase in cases and no apparent speeding up in treatment. The contrasts between the extremes represented by these two provinces, though not written in precise figures, undoubtedly provide a sound basis for comparison—probably a sounder basis than precise figures of pre-treatment durations which must be, on account of their character, of dubious accuracy and comparability. These contrasts are so marked that no one familiar with them could doubt that, if early treatment were effectual, there would be distinct differences between the breast cancer mortality trends of the two provinces. The lack of any difference between the trends of these two extremes or of any of the other provinces allows only one conclusion: that such early treatment has failed to effect any appreciable reduction in cancer mortality. When to this is added the recorded experience of England and Wales and of Massachusetts (*C.J.P.H.*, 1950, **41**, 230,240), which show, in spite of reported differences in conditions, practically identical level trends in the age-specific rates, the failure of early treatment appears abundantly confirmed. No other conclusion can be drawn, it is thought, without assumptions so fantastic that they must be rejected. When consideration is given to the cause of the failure of early treatment, the only reasonable deduction to be drawn, and one compatible with facts from all fields, is that in most if not all lethal breast cancer, spread occurs before interference is practical. (Mass mastectomy at any age cannot be considered a practical procedure.)

The clash between the high cure rates reported for Stage I and the failure of early treatment to reduce mortality rates is readily explained by the limitations of histopathology (*C.J.P.H.*, 1949, **40**, 257-269; 1951, **42**, 359-366). Histopathologists recognise and emphasise those limitations—especially the inability to distinguish between metastasising and non-metastasising tumours—though still with amazing inconsistencies and still with many of their clinical colleagues unaware or unconvinced of these limitations. (Indeed, not infrequently the clinicians naively defend their claims on the grounds that they themselves have checked the sections!) The widespread efforts now being made to find a more reliable basis than histopathology for prognosis reflect the widespread recognition of its limitations.

Dr. Donaldson quotes figures showing decreasing survivals with different stages. The evidence that stage is, as indicated, more an indication of type than of duration has been given in some detail previously (*C.J.P.H.*, 1951, **42**, 88-94). In fact, it is found throughout pertinent cancer literature, though often neglected in making comparisons and drawing conclusions. The difference between survivals of different stages is not evidence of difference between survivals of different durations.

Dr. Donaldson quotes (Table III) data showing decreasing five-year survivals with increasing durations previous to treatment. The few data available on the natural history of lethal breast cancer (the lethal character proven by death rather than postulated on a microscopic section) exhibit a pattern of decreasing five-year survivals with cases of consecutive durations quite similar to the pattern of survivals in the treated patients. That pattern reflects the mortality times of the usual types of lethal breast cancers. It is bound to vary with any selection. Obviously, as the pattern is found in the untreated, it cannot, when found in the treated, be confidently attributed to treatment at different periods (*C.J.P.H.*, 1951, **42**, 218-223).

Dr. Donaldson also quotes Dr. Smithers *et al.* as follows: "There is a steady downward trend in the mortality rate from breast cancer in England and Wales, after correction for changes in the age distribution of the female population" (*British Journal*

of Radiology, Supplement No. 4). Dr. Smithers based his statement on rates adjusted to eliminate the influence of differences in the age constitutions of the changing population. (On the preceding page in the report the age-specific rates were presented and were thus available for the authors and the readers.) With regard to such adjusted rates and with particular reference to cancer, the Registrar-General, as previously quoted (*C.J.P.H.*, 1952, **43**, 10-13), has cautioned as follows: "The study hitherto made of mortality trends for cancer sites by means of standardised rates at all ages combined was of limited value since it obscured great differences in the behaviour of rates at different periods of life, and these may be important in any attempt to elucidate the causes underlying the trends." Such adjusted rates not only obscure the truth but for those unaware of their hazards they distort it. They are misleading and are thus to be avoided as a basis for comparison. But this is not the only weakness of the figures from which Dr. Smithers drew his conclusion.

In an attempt to overcome the discontinuity produced by a drastic change in book-keeping, Dr. Smithers used a "correction factor" of admittedly questionable applicability on the pre-1940 annual totals of all ages combined. Had correction factors for each age group been available they would have differed widely for different age groups and their use with due care would have been less objectionable, but, as indicated later, still without any assurance of achieving comparability. The correction factor for the overall figure has a hazard similar to that of adjusting rates for age changes as noted, it obscures and distorts the actual picture. It is quite inadequate.

Further, it is altogether unlikely that the full effect of the change in the book-keeping would be revealed in a couple of years. As some time would be required for the medical profession to recognise and assume their newer responsibilities with regard to certification of death, their attitude and practice in this regard would, in all probability, continue to change for some time and produce artificial changes in the rates over an extended period. Thus the data since 1940 lack assurance of comparability even within themselves (*C.J.P.H.*, 1950, **41**, 230-240).

Lastly, abrupt declines to lower levels in the rates for all causes combined for the older age groups after 1940 cast some doubt on the reality of those declines. Some artificial factor independent of diagnosis is suggested. Whatever it might be, the cancer data would not be exempt from its influence. Until freedom from such an artifact in these later rates is assured or necessary correction made for this factor, they cannot be considered comparable with the earlier data even if adequate correction factors for other variables, as noted, had been used (*C.J.P.H.*, 1950, **41**, 230-240).

Thus, from many angles, to say nothing of the uncertainty of trend lines fitted to so short and variable a period, Dr. Smithers' basis is far from reliable. Indeed, it is surprising that the defective character of that basis should have passed at least two editorial chairs without being noted. That basis cannot take precedence over the fuller picture—the age-specific rates with due allowance made for discrepancies even in these (*C.J.P.H.*, 1950, **41**, 230-240).

It is to be noted, too, that, in the experimental observations cited by Dr. Donaldson, spread is not differentiated from the finding of metastases. It is self-evident that some time is required for metastases to develop to detectability and for the primary tumour to grow to a larger size. Some degree of correlation between number of metastases found and size or duration of the primary tumour is practically inevitable. The failure to detect metastases, clinical or experimental, is no evidence that spread—or all the spread—had not occurred.

The conclusion drawn from the experience of the past 25 to 30 years that in most, if not all, lethal breast cancers the spread occurs before the lesion is detectable or treatment practical clearly resolves and reconciles the contradictions, inconsistencies and conflicting claims of radically different techniques which Dr. Smithers finds so rife in the literature on cancer. Any other interpretation leaves those contradictions, inconsistencies and conflicts unresolved, and thus reveals its own inadequacies.

One word more. It is very difficult to see how, in the present state of our knowledge, reliable or comparable data on the incidence of breast cancer could be obtained. And collection of unreliable and incomparable data would not be profitable. We have to learn much more about diagnosis before attempting to obtain incidence figures directly.

N. E. MCKINNON.

Department of Epidemiology and Biometrics,
University of Toronto,
Canada.
September 26th, 1952.

SOCIETY OF MEDICAL OFFICERS OF HEALTH**NOTICES****THE ANNUAL DINNER**

Tickets, price 25s. (or 27s. 6d. if applications are received after 16th inst.) can still be obtained from the Executive Secretary for the Annual Dinner to be held at the Piccadilly Hotel, W.1, on Thursday, 23rd inst., 6.45 for 7.15 p.m.

ORDINARY MEETING

Formal notice of an Ordinary Meeting of the Society to be held at B.M.A. House, on October 24th, following the Council meeting is enclosed with this issue.

MATERNITY AND CHILD WELFARE GROUP**A Course on the Psychological Development and Welfare of Children**

At the request of the Maternity and Child Welfare Group, the Institute of Psycho-analysis are holding a course of nine lectures entitled "A psycho-analytical approach to some aspects of child development and welfare."

The lectures will be held at the Institute, 63, New Cavendish Street, on Fridays at 7.30 p.m., and will commence on October 17th, 1952.

The fee for the course is £2 2s., payable to the Treasurer, M. & C.W. Group. Application forms and further details of the lectures may be obtained from the Secretary, M. & C.W. Group, and should be returned by October 10th.

D. A. CRAIGMILE,
52, Mount Park Road, Ealing
(Hon. Sec. and Treasurer).
M. PATERSON,
64, Highgate West Hill, N.6
(Hon. Asst. Sec.).

SCHOOL HEALTH SERVICE GROUP

A general meeting of the Group will be held in Room 310, at the London School of Hygiene and Tropical Medicine, Keppel Street, Gower Street, London, W.C.1, on Friday, October 17th, 1952, at 5.15 p.m., when the Presidential Address will be given by C. Leonard Williams, M.R.C.S., L.R.C.P., D.P.H., entitled "Eureka."

A joint meeting will be held with the Medical Officers of Schools Association on Friday, November 21st, on Infectious Diseases.

A. A. E. NEWTH,
Hon. Secretary.

28, Chaucer Street,
Nottingham.

REPORTS**EAST ANGLIAN BRANCH**

President: Dr. R. A. Leader (M.O.H., Ipswich C.B.).

Hon. Secretary: Dr. A. J. Rae (Dep. C.M.O.H., West Suffolk).

A meeting of the Branch was held at the Area Health Office, Thetford, on Saturday, May 3rd, 1952, at 3 p.m. The President was in the chair and 14 members were present.

The Branch decided to support the nomination of Prof. Andrew Topping for the presidency of the Society during the session 1952-53.

Dr. Edmund Martin, of the Ministry of Health, gave a very instructive talk on Civil Defence and afterwards answered questions put by many of those present.

A meeting of the Branch was held at Purdy's Restaurant, Norwich, on June 21st, 1952, at 3 p.m. Fourteen members were present.

Dr. K. J. Grant, Medical Officer of Health, County Borough of Great Yarmouth, was unanimously elected President of the Branch for the coming session and the other officers were re-appointed.

Reference was made to Dr. V. F. Soothill's approaching retirement and it was agreed that the Branch should recommend that he be made a life member.

Members were reminded of Dr. S. T. G. Gray's years of service in Norfolk and Suffolk, and he was congratulated on being appointed to be County Medical Officer for East Suffolk.

The question was raised of financial assistance being provided by Local Authorities to assist Medical Officers who wished to take diplomas and higher degrees in health subjects, and, after some discussion, it was decided that the matter should be put on the agenda for the next meeting, to be held at Great Yarmouth on Saturday, October 4th, 1952.

After tea members and their visitors enjoyed a very interesting tour of Norwich Cathedral, which was conducted by Mr. Coleby, the Sub-Sacrist.

EAST MIDLAND BRANCH

President: Dr. J. H. C. Clarke (M.O.H., Kesteven (Lincs)).
Hon. Secretary: Dr. J. A. Stirling, D.S.C. (M.O.H., Chesterfield M.B.).

The annual meeting of the Branch was held at the Town Hall, Stamford, on Thursday, July 10th. The President was in the chair and 26 members were present.

The Hon. Secretary and Treasurer submitted his report and the balance sheet and drew attention to the financial situation of the Branch, due in the main to rising costs. The report and balance sheet were unanimously approved.

Elections for Session 1952-53.—The following Office Bearers were unanimously elected for the ensuing session: President, Dr. J. B. S. Morgan; President-elect, Dr. G. H. Gibson. Vice-Presidents, Drs. R. C. Holderness, E. B. B. Humphreys, J. H. C. Clarke; Hon. Secretary, Treasurer and Representative on the Council of the Society, Dr. J. A. Stirling; Branch Council, Drs. M. Allan, H. L. Barker, M. L. Bery, J. R. Byars, J. R. Graham, J. A. Kerr, C. W. W. Jeremiah, E. K. Macdonald, A. A. E. Newth, and E. M. Warwick; Co-opted Dental Associate Member, Mr. A. R. Little.

The members were then joined by their ladies and luncheon was taken at the Stamford Hotel at which the Chairman of the Kesteven Health Committee (Alderman Deer), the Mayor of Stamford, Alderman Mrs. Scholes and the Town Clerk of Stamford, Mr. Baldwin, were our principal guests.

After lunch a visit was paid to Burleigh House by kind permission of His Grace the Marquess of Exeter. This visit proved very interesting and many objects of historical interest were pointed out to us. On returning to Stamford, Mr. Ireson and Mr. Twilley conducted us on a tour of historic buildings including a visit to the Parish Church where the Vicar of Stamford conducted us round.

Tea was then taken in the grounds of the Maternity and Child Welfare Centre at the conclusion of which Dr. and Mrs. Clarke were warmly thanked for their kind hospitality in providing tea and for the excellent arrangements for our visit, on the proposition of Dr. Morgan, seconded by Dr. Gibson.

HOME COUNTIES BRANCH

President (1951-52): Dr. F. G. Brown (M.O.H., Wanstead and Woodford M.B.; Area M.O., Essex).

Hon. Secretary: Dr. J. Maddison (M.O.H., Twickenham M.B.; Area M.O., Middlesex).

On May 9th, 1952, the Branch paid a visit to Harlow New Town, when members were welcomed at the headquarters of the Harlow Development Corporation by Mr. W. Eric Adams, o.b.e., General Manager. Mr. Adams, who was supported by Dr. S. J. L. Taylor, gave a most interesting talk on the development of the New Town and subsequently both he and Dr. Taylor answered a number of questions on the work of the Corporation.

After lunch members were taken by coach on a conducted tour of the New Town, which included a visit to the Health Centre. Tea on return to the headquarters concluded a very enjoyable day.

On June 13th, 1952, the Branch paid a visit to Preston Hall, British Legion Village, Maidstone, Kent. In the morning Dr. F. Temple Clive, Physician-Superintendent, Preston Hall Hospital, gave a most interesting talk on the problems and difficulties of the rehabilitation of the tuberculous, and Mr. A. A. Howick, Secretary-Administrator, spoke of the work of the British Legion Industries. After lunch a tour was made of the hospital and industries. Members had an opportunity of seeing at first hand the excellent work being carried out by the British Legion in the training, rehabilitation and settlement of ex-service men and women suffering from pulmonary tuberculosis. The rehabilitation and settlement facilities comprise a village of 130 houses and workshops capable of providing sheltered employment and vocational training in a variety of occupations. Medical treatment is the responsibility of the Regional Hospital Board.

A meeting of the Branch, to which members of the Metropolitan Branch were invited, was held at 3 p.m. on Friday, July 11th, 1952, at the London School of Hygiene and Tropical Medicine, London, W.C.1. The President of the Home Counties Branch was in the chair and 41 members were present.

Dr. E. Hinden, M.D., M.R.C.P., Paediatrician, Whips Cross Hospital and Consultant Paediatrician to the Education Committee, County Borough of West Ham, gave a most interesting and stimulating address entitled "The Changing Face of Paediatrics" (printed on other pages of this issue).

The Hon. Secretary reported that Dr. Malcolm Manson, who joined the Society in 1920, had recently retired from the position of Medical Officer of Health, Wood Green Municipal Borough. He was eligible for Life Membership of the Society and it was unanimously resolved that his name should be put forward to the Council of the Society for nomination as a fully-paid Life Member.

The following officers and representatives were elected to serve for the session 1952-53: President, Dr. J. Maddison; Hon. Treasurer, Dr. K. E. Tapper (re-elected); Hon. Secretary, Dr. F. G. Brown; Representatives on the Council of the Society, President, Hon. Secretary and Dr. C. Herington (re-elected).

MIDLAND BRANCH

President (1951-52): Dr. C. Starkie (M.O.H., Kidderminster O.W.).

Hon. Secretary: Dr. W. Alcock (M.O.H., Burton-on-Trent C.B.).

The Annual Meeting was held at the premises of Messrs. Carpet Trades Ltd., Kidderminster, on Thursday, July 10th, 1952. The President was in the chair and 32 members attended.

The following were elected as officers and representatives for 1952-53:—

President: Dr. H. M. Cohen.

President-Elect: Dr. Jean M. Mackintosh.

Vice-Presidents: Drs. R. H. H. Jolly, G. Ramage, W. R. Martine, T. M. Clayton and C. Starkie.

Elected Members of Council: Drs. J. E. Geddes, J. W. Pickup, H. Paul, S. W. Savage, C. Cookson, M. Burn and J. F. Galloway.

Hon. Treasurer: Dr. A. J. B. Griffin.

Hon. Secretary: Dr. W. Alcock.

Hon. Auditors: Drs. T. M. Clayton, J. W. Pickup.

Representatives on the Council of the Society: Drs. W. Alcock, T. M. Clayton.

Representatives on Tuberculosis Group: Drs. J. E. Geddes and T. V. R. Philip.

Representative on Midland Tuberculosis Society: Dr. T. M. Clayton.

Representative on City of Birmingham Public Health Advisory Committee: Dr. W. R. Martine.

Representatives on the B.M.A.: Staffordshire Branch, Dr. J. A. M. Clark; Midland Branch, Dr. W. R. Martine.

Dr. J. McGarrett, formerly Medical Superintendent of the City Hospital, Birmingham, is recommended for life membership, and being eligible, Dr. Martine moved, Dr. Ker seconded, and it was unanimously resolved, that Dr. McGarrett's nomination for life membership be forwarded to the Council of the Society.

At the conclusion of the meeting members were joined by their guests and were first shown a film illustrating the various processes of carpet manufacture. This was followed by a conducted tour, in which all the stages from the preparation, dyeing and weaving of the wool, to the finished Wilton and Axminster carpets, were carefully explained. Members were impressed by the efforts made to ensure that the surroundings in which the carpets are made are not only healthy and functionally efficient but also colourful and conducive to the happiness of the workers. It was also interesting to note that considerable efforts have been made to remove smoke and grit nuisances by modern mechanical stoking and grit arrestors.

At the conclusion of the tour the party were entertained to tea by the Directors of the firm. A cordial vote of thanks was proposed by the President (Dr. C. Starkie) and seconded by the President-Elect (Dr. H. M. Cohen). Dr. Martine and Dr. Clayton also thanked the President (Dr. Starkie) for his efforts in making this visit such an enjoyable one.

NORTHERN BRANCH

President (1951-52): Dr. I. V. Walker (M.O.H., Darlington C.B.).

Hon. Secretary: Dr. W. S. Walton, g.m. (M.O.H., Newcastle-on-Tyne C.B.).

The annual summer meeting of the Northern Branch was held at Barnard Castle on Friday, July 4th, 1952. Twenty-nine members attended, together with guests. Prior to the meeting a visit was paid to Bowes Museum, and tea was taken at the Rose and Crown, Romaldkirk.

Medical Manpower Committee.—The President reported that Dr. C. B. McGregor (Morpeth) had been proposed as an additional nomination by the Northern Sub-Group of the County District Group.

Resignation of Dr. J. C. Birchall.—The resignation of Dr. J. C. Birchall, Middlesbrough, was received and the Branch expressed its good wishes to Dr. Birchall on his new appointment at Croydon.

Public Health Service Defence Trust.—The President submitted a letter from the Secretary of the Society asking

Branches to encourage contributions to the Trust. In view of assistance given as a result of the Durham C.C. closed shop policy, he further stressed the need for adequate funds.

Election of Officers, etc.—The following officers were elected for 1952-53: President, Dr. H. J. Peters (Stockton); Vice-President, Dr. W. G. Patterson (Newcastle R.H.B.); Hon. Secretary and Treasurer, Dr. W. S. Walton (Newcastle); Branch's Representative on Council, Dr. A. S. Hebblethwaite (Sunderland); North of England Branch of B.M.A., Drs. J. Grant (Gateshead) and W. J. Pierce (Northumberland C.C.); Newcastle-upon-Tyne Division of B.M.A., Drs. W. S. Walton (Newcastle) and W. Minns (Northumberland C.C.); Tuberculosis Group Committee, Dr. A. B. White (Sunderland).

Subscriptions to B.M.A.—Membership of the B.M.A. and the value of the B.M.J. to Medical Officers was discussed, one point being that whereas general practitioners were allowed income tax rebate on the subscription paid, Medical Officers were not. It was generally agreed that whereas membership of the B.M.A. and receipt of the B.M.J. was desirable, Medical Officers felt entitled to a reduced fee to compensate for additional income tax paid.

NORTH-WESTERN BRANCH

President (1951-52): Dr. A. M. M. Grierson (Dep. M.O.H., Manchester C.B.).

Hon. Secretary: Dr. J. S. G. Burnett (M.O.H., Preston C.B.).

The annual meeting of the Branch was held at Langho on Friday, June 13th, 1952, when 35 members and guests attended.

The annual report of the Hon. Treasurer was approved and it was agreed that a further £20 be invested in Defence Bonds at the discretion of the Treasurer.

The election of officers and committee for the session 1952-53 took place, when the following were elected:—

President: Dr. K. K. Wood.

Vice-President: Dr. A. M. M. Grierson.

Hon. Secretary: Dr. J. S. G. Burnett.

Hon. Treasurer: Dr. J. Yule.

Representatives on the Council: Drs. J. Yule and J. S. G. Burnett.

Committee: Drs. H. G. M. Bennett, C. Metcalfe Brown, F. W. C. Browne, S. C. Gawne, J. G. Hailwood, J. Innes, E. M. Jenkins, J. T. C. Keddie, C. H. T. Wade, E. H. Walker.

The members were then shown round the Langho Colony for Epileptics and subsequently entertained to tea by the President.

WEST OF ENGLAND BRANCH

President: Dr. A. A. McCall (M.O.H., Chard, Ilminster, etc.; A.C.M.O., Somerset).

Hon. Secretary: Dr. R. H. G. H. Denham (M.O.H., Bathavon, Keynsham and Frome; A.C.M.O., Worcestershire).

A meeting of the Branch was held in the Pump Room, Bath, on Saturday, May 3rd, 1952.

The meeting was preceded by a luncheon which was attended by 21 members and 10 guests. In the absence of the President Dr. Cormack acted as Chairman.

The Hon. Secretary reported that the points raised by Dr. Cookson regarding the investigation of maternal deaths had been referred by the Council of the Society to the General Purposes Committee for further consideration. Considerable discussion took place on a resolution contained in a communication received from a group of district medical officers in Wiltshire to the effect that in any future negotiations concerning conditions of service and salaries Medical Officers of Health should have representation comparable with that enjoyed by the general practitioner. It was decided to support the resolution. An amendment that there should be N.A.L.G.O. representation in Whitley Committee C was defeated.

The Chairman referred to Prof. Parry's appointment as Honorary Physician to Her Majesty the Queen and offered him sincere congratulations on behalf of the Branch members.

A most interesting talk was given by Prof. Lennon, Professor of Midwifery and Gynaecology at Bristol University, entitled "Some Views on Maternity Service" (see PUBLIC HEALTH, September, 1952).

Thanks to the speaker for his stimulating and instructive talk were proposed and seconded by Drs. Thomson and Morris-Jones.

A meeting of the Branch was held at the Fortfield Hotel, Sidmouth, on Saturday, July 12th, 1952.

The meeting was preceded by a luncheon which was attended by 16 members and 10 guests.

A lengthy discussion took place as to the necessity for additional powers and legislation for dealing with contacts and carriers of infectious disease and it was decided to submit the following resolution to the Council of the Society for their consideration:—

"That pulmonary tuberculosis be included in the list of diseases notifiable within the meaning of the Public Health Act, 1936."

A suggestion by Dr. Midgley that a joint meeting be held with the Tuberculosis Standing Sub-committee of the Regional Advisory Committee of the South-West Regional Hospital Board to discuss Mass Miniature Radiography, its functions, scope, relations with other departments, etc., was favourably received and it was decided to hold such a meeting some time in November.

Dr. Davidson and Dr. Cookson were re-elected the County and County Borough Representatives respectively on the Regional Medical Advisory Committee of the S.W. Regional Hospital Board.

The President referred to the increase in B.M.A. subscriptions, and after much discussion it was agreed that a resolution be sent to the Council of the Society requesting them to ask the British Medical Association to accept members of the Public Health Service at the same rate of annual subscription as members of the armed forces.

The following officers were appointed for the 1952-53 session:—

President.—Dr. Catherine Morris-Jones, Medical Officer, Maternity and Child Welfare, Gloucestershire.

President-Elect.—Dr. J. Macrae, Medical Superintendent, Ham Green Hospital, Bristol.

Hon. Secretary and Council Representative.—Dr. R. H. G. H. Denham, M.O.H., Bathavon, Keynsham and Frome.

Hon. Treasurer.—Dr. B. A. Astley Weston, M.O.H., Bath C.B.

Representatives for Tuberculosis Groups.—Dr. R. L. Midgley, Medical Superintendent, Hawkmoor Sanatorium, Bovey Tracey, Devon, and Dr. J. Macrae.

COUNTY DISTRICT GROUP

President (1951-52).—Dr. C. Leonard Williams (M.O.H., Barking M.B.; Area M.O., Essex).

Hon. Secretary.—Dr. R. C. M. Pearson (M.O.H., Watford M.B.; Divl. M.O., Herts).

The Annual Meeting of the Group was held at St. George's Hotel, Cliftonville, Margate, on Tuesday, April 22nd, at 8.15 p.m. The meeting was well attended, over 100 members being present.

The President was in the chair and Dr. J. Menzies Cormack was acting secretary.

The minutes of the Annual Meeting, 1951, were approved.

Election of Officers, 1952-53

The following recommendations of the Executive Committee were approved:—

(a) *President*.—Dr. J. D. Kershaw (M.O.H., Colchester).

(b) *Vice-President*.—Dr. G. H. Pringle (M.O.H., Worthing).

(c) *Hon. Secretary and Treasurer*.—Dr. G. H. Pringle (M.O.H., Worthing).

(d) *Hon. Assistant Secretary*.—Dr. J. H. Hudson (M.O.H., Dartford M.B. & R.D.).

Selection of Executive Committee

Ex officio.—The President, the Honorary Secretary and Honorary Assistant Secretary.

The following nominations by the Sub-Groups were agreed:—

Sub-Group	Nomination
North-West ...	Dr. F. W. Campbell Brown
Northern ...	Dr. J. H. Maughan
Welsh ...	Dr. J. Alun Evans
East Anglian ...	Dr. J. C. Johnston
West of England	Dr. J. Menzies Cormack
Southern ...	Dr. John Sleigh
Home Counties	Dr. C. E. Herington
East Midlands	Dr. H. L. Barker
Yorkshire ...	Dr. F. Appleton

With regard to the names put forward for ballot, Dr. A. C. Taylor moved and the resolution was agreed that only one of the names put forward by each Sub-Group be accepted, making a total of six, and the selection from each Group be agreed by correspondence. In addition, Dr. Belam moved and it was carried unanimously that Dr. Stirling's name be added to the list.

Discussion with County Medical Officers of Health Representatives.—Due to the absence from the meeting of the members stated above, the meeting elected Drs. Hailwood, Belam and Peters to attend the following day at the Town Hall.

Matters for General Discussion put forward by the Sub-Groups

Division Administration.—Dr. Barker and Dr. Sleigh spoke on "The Fate of the Memorandum on Divisional Administration," and Mr. Elliston pointed out that the Memorandum had not been accepted so far but that the Council of the Society had appointed several of their members to meet both groups the

following day so that the Council of the Society would be in a position to define a policy in default if this course were necessary.

Duties of the District Medical Officer of Health.—Dr. McCall made general remarks on the time allowed for the respective duties of a District Medical Officer of Health and suggested that the time allowed could be defined on a population basis and such population could be based generally on 100,000. The following members took part in the discussion:—

Dr. Stirling (who compared a similarly dangerous position in 1875), Dr. Thomson of Hereford, Dr. Harford of Abingdon, Dr. Sleigh, Dr. Maughan and Mr. Elliston (who pointed out that appeal to the Minister was available under Sanitary Officers' Regulations).

It was resolved (moved by Dr. Donovan) that the whole matter be referred to the Executive Committee. A previous resolution by Drs. Maughan and Reynolds that there be no further discussion and no delineation of duties was lost.

Local Government Manpower Committee—Second Report.—It was suggested by Dr. Peters that this memorandum on delegation by County Councils should be brought to the notice of the District Councils.

Combined Appointments, Etc..—Dr. Hudson spoke for some time on the question of "When is a combined appointment not a combined appointment?" In his own case a dispute had been established and after some discussion in which the following members took part (Drs. Reynolds, Hoey, Wright and Landon and Mr. Elliston), it was moved by Dr. Hudson and seconded by Dr. Landon that there be reference to the Council of the Society to look again into the question of combined and mixed appointments and to take all necessary action, including legal advice. This resolution was unanimously carried.

Streptococcal Carriers.—Dr. Charrett agreed to forgo discussion on this item.

Salary of the Medical Officer of Health, Etc..—(a) A general discussion took place on the item raised by Dr. Sleigh on "The present salaries of Medical Officers of Health," and after a statement by Dr. Stirling the discussion was closed.

(b) After some general discussion on the following items it was resolved to refer both to the Council of the Society.

(i) "That representations be made to the Staff side of Committee 'C' with a view to pressing local health authorities to have regard to the years of service when assessing the salaries of D.M.O.s who, prior to the appointed day, held appointments with former autonomous maternity and child welfare authorities."

(ii) "That this Sub-Group deplores the present designation and salary scale of Assistant Medical Officers and presses the Staff side of Committee 'C' to pursue the matter of improvement of such posts at an early date."

Ministry of Health Circulars, 6/52 and 7/52.—Dr. Charrett made reference to Ministry of Health Circulars 6/52 and 7/52, and both were referred for discussion to the Executive Committee with power to act.

Short Questions.—Dr. Parfitt read out a number of questions. These were agreed to be of very great interest but no particular decisions were made (chiefly because of the late hour and fatigue of the members).

Date and Place of Next Meeting.—It was moved by Dr. Reynolds of Wiltshire, and seconded by Dr. Wright of Salisbury, that two meetings be held each year, one at the Royal Sanitary Institute Conference and the other in the provinces, during this year. It was agreed that the second meeting this year be held at Birmingham.

COUNTY MEDICAL OFFICERS OF HEALTH GROUP and Association of County Medical Officers of Health of England and Wales

President (1951-52).—Dr. C. Milliken Smith (C.M.O.H., Northamptonshire).

Hon. Secretary.—Dr. T. Ruddock-West (C.M.O.H., Norfolk).

A successful series of meetings has been held during the past six months, during which a number of interesting papers were given and several subjects exhaustively discussed. Amongst these was a discussion on the Local Government Act, 1933, Section III, which gave rise to a lively exchange of views; several members contributed papers and some interesting facts and figures were obtained.

Other exceedingly useful contributions were a talk entitled "The Significance of Some Defects in Children's Feet," given by Mr. T. T. Stannin, Surgeon i/c Orthopaedic Department, Guy's Hospital, which was preceded by a film, kindly lent by the Central Film Library; a comprehensive survey of the New

Zealand Dental Scheme and a talk on the value of fluorine in connection with children's dentistry, given by Dr. A. T. Wynne, of the Ministry of Education; also a review of Civil Defence plans and a description of the duties of the Medical Officer of Health in Time of War, by Dr. A. E. Martin, of the Ministry of Health.

The last meeting in the series was occupied by a visit to the Queen Mary's Hospital for Children at Carshalton, where Dr. C. D. S. Agassiz, Physician Superintendent, demonstrated methods of treatment of poliomyelitis and cerebral palsy. Dr. Agassiz stated that in poliomyelitis he believed there was a concurrent inflammation of the connective tissue, which was followed by contraction, and it was important to break up this tissue by appropriate massage and by hot baths and hot and cold packs.

In the cerebral palsy unit it was explained that the aim of treatment was to educate the patient to perform normal movements. Many cases of cerebral palsy had been wrongly diagnosed as mental defectives in the past, and a number of them, particularly in the athetoid group, were intelligent. Photographs of cases before and after treatment gave clear evidence of the success of the methods employed.

Dr. Agassiz stressed the need for early diagnosis and treatment in both poliomyelitis and cerebral palsy, if good results were to be obtained. He also mentioned that when he first took over the cerebral palsy unit he found such a large waiting list that he devised the system of inviting parents to take up residence near the hospital for a few days, during which time the children were treated as out-patients and the parents instructed in how to handle them and continue the treatment. This scheme had proved very successful.

Mrs. Irene Collis also addressed the members and special education methods followed in teaching cerebral palsy children were seen.

MATERNITY AND CHILD WELFARE GROUP

President (1951-52): Dr. Anna B. Gardiner (Sen. A.M.O.H., Kent C.C.).

Hon. Secretary (1951-52): Dr. Kathleen M. Hart (Sen. Ass't Div. M.O., Ealing and Acton (Area 2), Middlesex).

Week-end Post-graduate Course, London, June 28th, & 29th

On Saturday, June 28th, the Group met at the Middlesex Hospital. Mr. Ian Jackson, obstetrician at the hospital, discussed the frequency with which placaeae praeviae were found, on the average in 1:200 births, although in hospital populations the rate was naturally much higher. Of the theories of causation, Mr. Jackson mentioned the abnormal implantation of the ovum, the persistence of chorionic villi and the possibility of a decreased blood supply to the uterus resulting in an abnormally large placenta. In 3·6% of cases of placenta praevia the foetus was abnormal.

The most dangerous type of placenta was that lying posteriorly, as there was more likelihood of the cord being occluded in labour.

Diagnosis could often be made by soft tissue x-rays which had superseded radioisotopes and arteriograms as a method of diagnosis.

Mr. Jackson went on to discuss treatment. Wherever possible the patient should be kept under ward supervision until the baby was a reasonable size. No vaginal examinations were done, and, except in cases of severe or prolonged loss, Caesarean section was performed at 38 weeks. In a few cases seen for the first time in labour with only a moderate loss, the membranes were ruptured and labour allowed to continue.

After a break for coffee we were shown some interesting cases by other members of the staff. Dr. Furze discussed three cases of foetal abnormality diagnosed intranatally. Mr. Crawford showed a 9 lb. baby born of a mother with controlled diabetes. The baby, despite its size, was three weeks premature and behaved in all respects like a true premature baby. Dr. Webb discussed the treatment of serotental fibroplasia, an interesting piece of research which he had the opportunity to study at the hospital.

After a discussion and many questions which were willingly answered by our lecturers, Dr. Paterson proposed a vote of thanks to the staff of the hospital who had contributed to a most interesting morning.

On Saturday afternoon the Group met at the London School of Hygiene and Tropical Medicine, where Mrs. Hume, Chairman of the London Marriage Guidance Council, described the work done by the local councils. This, she said, fell into three parts: remedial, the education of young people and the preparation of engaged couples for marriage. She described the selection and training of marriage guidance counsellors.

Dr. Mary Macaulay, Senior Medical Officer, of the Family Planning Association in Liverpool, who followed Mrs. Hume, spoke on the human aspect of the subfertile marriage. Too many cases, she said, were treated as a "diseased pelvis" and

the handling of the individuals concerned was therefore unsatisfactory. She mentioned the points to be looked for and the type of cases which can benefit from advice. She made a plea especially that the patients should be told of the implications and results of the tests which they had undergone.

Dr. Helena Wright, of the Family Planning Association, based her talk on the assumption of the rightness of the planned family. She outlined the history of the Family Planning Association and discussed the principles of good contraceptive instruction. The patients should return for review every six months and this gave a useful opportunity for the clinic doctor to keep a check on their general health. There was no recognised training course given by any teaching hospital, but the association arranged to give training at their clinics.

Although the Royal Commission on the Population recommended a family planning service only about half the local health authorities co-operated or gave facilities to the association.

A lively discussion followed the three speakers and in conclusion a vote of thanks was proposed by Dr. Nithsdale.

On Sunday, Dr. J. W. B. Douglas, the Director of the National Survey of the Health and Development of Children, spoke on

the health and growth of premature children during the first five years of life.

All babies born in a certain week in 1946 were included in the survey, in which 700 prematures were matched with a full-term control, thus eliminating one of the factors causing discordant results in previous surveys. The figures in the one to four years age group showed a slightly higher mortality rate in the prematures, the causes of death being respiratory infections, congenital abnormalities and a small but significant number from nephritis. Excluding specialised care at birth, rather more premature babies required hospital care during the first two years of life, especially where the birth weight had been under 4½ lb.

Premature babies tend to come from poorer families, but, when the infectious disease experience is compared in matched pairs, this appeared to be very similar.

As regards the physical characteristics, premature children tend to be lighter and smaller than their control pair. While this may be partly genetic, the smallest premature babies tended to catch up with the controls while the 4 to 5½ lb. group did not. Babies born of abnormal pregnancies caught up with their controls much faster, possibly because the genetic factor was not involved.

Intellectually walking and habit training occurred later in premature children and was related to the length of gestation.

This survey, said Dr. Douglas, went to disprove Hutchinson's maxim that premature children were genetically inferior.

After an interesting discussion Dr. Violet Russell proposed a vote of thanks to Dr. Douglas.

DENTAL OFFICERS' GROUP

President : Kevern Batten, L.D.S. (Chief D.O., Cornwall C.C.).

Hon. Secretary : J. F. A. Smyth, L.D.S. (Chief D.O., Gloucestershire C.C.).

The Annual General Meeting of the Group was held at Tavistock House South on Saturday, July 26th, 1952, at 2.30 p.m., and was preceded by a lunch which was given in honour of Mr. and Mrs. J. V. Bingay, at the Holborn Restaurant. Twenty members of the Group were present at the meeting, and apologies for absence were received from Miss E. M. Knowles, Miss M. S. Cosh, Mr. S. B. Newton and Mr. J. D. Sykes. Under Reports of Officers, Mr. J. V. Bingay, speaking as Chairman of the Group Council, said that four well-attended meetings of the Council had been held during the year, and that although nothing dramatic had transpired as a result of their deliberations much intricate work, and also work of a confidential nature, had been carried through which had met with much success. The Council had been concerned during the year with the Dentists Bill and the amending N.H.S. Act, both of which affected the general dental services equally with themselves. As regards the Dental Whitley Council recommendations, these had been universally implemented as regards assistant dental officers. Some authorities were, however, still holding out in respect of Chief Dental Officers, but it was hoped that in a very few weeks they, too, would come into line. The discretionary clauses, unfortunately, had not always been very realistically applied. An appeal by a retired Chief Dental Officer had, through the British Dental Association, been taken to the Regional Appeals Tribunal, where a favourable result had been secured. In conclusion Mr. Bingay referred to the Joint Circular issued on June 30th by the Ministries of Health and Education which indicated quite clearly that there was no intention that the service should be reduced to one of dental inspection only. It was now up to everyone, Assistant and Chief Dental

Officers alike, to do their utmost to put their battered service back on its feet again. (For details of other officers' reports, see Report of Group Council.)

Election of Officers. The officers for the session 1952-53 were elected as follows. *President-Elect* : S. B. Newton. *Immediate Past President* : J. V. Bingay. *Vice-Presidents* : P. G. Oliver, John Young, K. C. B. Webster. *Hon. Treasurer* : A. G. Taylor. *Hon. Secretary* : J. F. A. Smyth. *Hon. Editor of Transactions* : J. Fletcher. *Assistant Hon. Secretary* : Miss A. S. Stewart. *Hon. Membership Secretary* : M. Cohn. *Members of Group Council* : R. B. Dinsdale, Miss W. M. Hunt, J. C. Robertson, E. Kew. *Hon. Auditors* : Miss Hunt and W. L. Cooper Jones.

Valedictory Address

In delivering his valedictory address, Mr. J. V. Bingay said how much he had enjoyed his year of office and how much pleasure the luncheon party preceding the meeting had given to himself and his wife. They had all been passing through very anxious and tiring times but he hoped that they had not yet lost their edge. He had been supported by very able officers. Mr. Smyth had been his right-hand man and was a most able secretary. Mr. Taylor, as Hon. Treasurer, had proved a financial genius. Mr. Fletcher had been a pillar of strength and an old and tried war horse. Mr. Webster had a way of getting right into the inner councils of things and he trusted that they would have him with them for many years to come to help in the way which only he could. He had much pleasure in installing Mr. Kevern Batten, who was so well known to them all, as their new President.

Presidential Address

Mr. Batten thanked the Group for the high honour they had bestowed upon him. He had accepted with some diffidence, realising how difficult it would be to carry out his duties with the dignity and power of oratory which had distinguished so many of his predecessors. His first introduction to the Society had been in 1928, when he had read a paper before a Group of Assistant Medical and Dental Officers in Cardiff. This Sub-Group in Wales had, he thought, been the first so instituted and he hoped to see more sub-groups come into being in the near future, especially now that there was every indication of the Public Dental Service at long last coming into its own. He was already due for retirement but had agreed to remain at work for a further year. This would, therefore, be something of a swan song and he proposed to "reminisce" and to give an outline of his experiences in the school and public dental services covering nearly 40 years. His first appointment had been as part-time dental surgeon to the City of Bath, and he told of an amusing incident which had occurred at the selection committee prior to his appointment. The dental condition of the children was at that time terrible. Quite 96% of them needed dental attention and most of them needed it badly. For the first year or so it had been necessary to devote half of the time available to the cleaning up of very septic mouths under a general anaesthetic administered by the school medical officer. Routine inspection was at first limited to the six to nine years age group—the remainder being treated by request. Re-inspection in following years allowed the routing age to be extended. The average number of attendances per child was 2.8 and the average amount of work necessary per child was 2.32 fillings and 5.24 extractions. The acceptance rate at the end of the first year was 56% which, considering that a call for dental treatment was thought by many parents to be an interference with the liberty of the subject, was most encouraging. One interesting point which he had noted was that in 1912, in Bath, the number of children recorded as having enlarged tonsils was 43%. After he had been there two years the figure had fallen to 7.1%. He had then been successful in persuading the then School Medical Officer to defer from tonsil operations the worst of those children whose mouths were in a septic condition and simply to clean up the dental condition and watch results. It had been rather surprising to him to see the large number of children whose tonsils had returned to normal with this treatment alone. It was also interesting to look back on the large number of irregularities and malocclusions he had found to exist when he inspected in 1913-14; no school dental service had then existed to pull out all their temporary molars! In 1926 he had left Bath to become whole-time school dental officer to the Rhondda Urban District Council. He had expected to have three assistants but found that he was single-handed to deal with a school population of 32,500 out of a total population of 159,270. It was then a distressed area. He was also somewhat distressed. Two years later a new dental centre was equipped and opened in the recently built Carnegie Welfare Centre, which had cost £36,000. He was now given his first assistant, but no increase in salary. After remaining there for four years he had gained an appointment

under the Devon County Council, where much travel was necessary and all treatment carried out on the school premises, often under somewhat adverse conditions. He had often to visit two schools in one day, unpacking and packing his equipment on each occasion. His area had extended from near to Bude on the North Cornish border down to the outskirts of Plymouth and across Dartmoor almost to Exeter. In 1932 he had obtained a post under the West Riding of Yorkshire County Council. In view of the recent difficulty in obtaining applicants for public dental appointments it was interesting to recall that it was nothing unusual at that time for 80 or more applications to be received for each post. He had at first again been set to work amongst the coal fields but had later been transferred to a country area. He remembered working in one school on the Lincolnshire border where no water supply other than surface water existed. He had worked in a little chapel where there was no drainage and the contents of the spittoon were scattered outside on the green. In 1935, when a senior dental officer was appointed, a complete dental centre was established in the County Hall at Wakefield. Provision was made for the administration of general anaesthetics for extractions, orthodontic work was undertaken, and an x-ray apparatus provided. In 1938 the dental staff was increased to 39 and the dental areas became more manageable. The school dental service now seemed to be approaching the state so long wished for; but the advent of war "put paid" to much of this. He was able to look back with much pleasure to the happy time he had spent in Yorkshire. The experience had been most varied and instructive, but age was creeping on and he had felt an urge to get back to his own West Country and had sought and secured in 1944 an appointment with the Cornwall County Council. There, although previously all treatment had been given in the schools themselves, frequently under very difficult conditions, he was given permission to establish dental centres of a temporary nature in Bude, Launceston and Camelford, where in each hot and cold water, gas and electricity were available. This had allowed him later to introduce electric engines, lights and sterilisers of a portable type. The experience thus gained had encouraged him later to embark on a centralisation scheme using more permanent and fully equipped dental centres when he had been appointed Senior Dental Officer in 1946. These he had described in a paper which he read before the Group some few years previously. He was glad to say that 18 of his proposed 21 centres were in full working order. The 19th would be contained in a prototype health centre which his authority were now building. He had a central laboratory in Truro with a chief technician and two apprentices. The laboratory was well equipped and able to undertake any type of mechanical dentistry. All treatment had now for some time been carried out in the dental centres and the dental officers had expressed themselves as being well satisfied with the results. Parents and children were becoming proud of their dental centres. The approach to the one in Launceston was through the old castle grounds; in Bude the centre was in the castle on the sea shore and was approached through beautiful gardens; in Bodmin the centre was in an old Priory and in the grounds was a big lake having an island in it which from January onwards was a blaze of colour provided by camellias, rhododendrons, azalias and hydrangeas. They had no centres shut up in back streets. He hoped that the picture he had been able to give would in spite of setbacks show the very great strides which had been made in the past 40 years, which after all, from the social point of view, was quite a short period. A vote of thanks to the retiring and new Presidents was proposed by Mr. Webster and seconded by Miss Hunt.

Group Council

A meeting of the Group Council was held at Tavistock House South on Friday, July 25th, 1952, at 5.30 p.m. The Chairman of the Group Council, Mr. J. V. Bingay, presided, and also present were : Messrs. K. Batten, M. Cohn, H. B. Fleming, J. Fletcher, E. Kew, J. C. Robertson, J. F. A. Smyth, A. G. Taylor, K. C. B. Webster, J. Young and T. H. Liptrot, Observer from P.D.O. Group of the British Dental Association. Apologies for absence were received from Miss W. M. Hunt, Miss A. S. Stewart and Mr. R. B. Dinsdale.

The Minutes of the previous meeting of the Council having been circulated were confirmed and signed.

Arising from the Minutes.—Mr. A. G. Taylor, Hon. Treasurer, reported that the Group's share of the cost of the Dental Officers' exhibit at the Dental Health Exhibition in connection with the International Dental Congress worked out at £15, which it was expected would be paid for out of a fund very generously bequeathed to the School Dental Society by one of its founders and first members. A vote of thanks and appreciation was accorded to Mr. Taylor for his work in connection with the exhibit. Mr. Taylor further reported that he had obtained an

estimate from Messrs. Fattorini & Sons, Ltd., for six past-presidents' replicas of the Presidential emblem. The cost of the replicas, including purchase tax, would be £2 10s. 6d. each. It was thought that in most cases recipients would be quite pleased to make a donation towards the Group funds when receiving their mementos of their year of office. Detail consideration of the matter of these emblems was referred to the Economy Sub-Committee with power, if thought fit, to take action. As the Joint Committee had not met since the last meeting of the Group Council, it had not been able to consider the Society's request for a memorandum on the future of the Local Authority Dental Services. Mr. Fletcher and Mr. Smyth, therefore, asked to bring before the Group Council a memorandum which they, at the request of the Executive, had prepared at Easter and had revised to some extent in the light of later happenings. There was a sharp division of opinion on the Council as to the desirability of producing a memorandum at the present time, especially as the position of the service had been greatly strengthened by the issue of the combined circular Ministry of Health 22/52 and Ministry of Education 254, dated June 30th, 1952. It was resolved that the document should "lie on the table."

Correspondence.—A letter had been received from the Dental Technicians Joint Negotiating Body asking that the Group should discuss with them the introduction of technicians as ancillary workers under the Dentists Act, suggesting that such a course would tend to concentrate the dentists' work on conservative treatment. The Hon. Secretary was instructed to acknowledge the letter and indicate that the matter was outside the scope of the Group's activities.

Reports of Officers.—The Hon. Treasurer was in the happy position of being able to report that expenditure had been brought within reasonable bounds and only exceeded income by a very small amount. The Council thanked Mr. A. G. Taylor for his very able handling of the Group's finances.

The Hon. Editor of Transactions reminded the Council that this was his 11th year as Hon. Editor. Members would have noted two editorials in PUBLIC HEALTH during the year and one full-length paper by Mr. H. D. Freeman on "Orthodontics in the School Dental Service." Notices of other Group meetings had appeared under Branch and Group Reports. A vote of thanks was accorded to Mr. Fletcher in appreciation of his work.

The Hon. Membership Secretary reported that there were now 127 members of whom 18 had been elected Fellows of the Society. The result of the recruiting appeal sent out by the President and Hon. Secretary had been disappointing. The strength of the Group was now 10 less than last year. It was resolved that a personal letter be sent to all Senior Dental Officers asking for their support. The Chairman thanked Mr. Cohn for his report.

The Hon. Secretary reported that the Group Council had met four times during the year and had transacted much important business. The results of their deliberations, if disappointing at times, had on the whole been satisfactory. He regretted that it had not been possible to hold the annual dinner during Mr. Bingay's Presidency, but commended to members the lunch which was being given in Mr. and Mrs. Bingay's honour on the following day. A unanimous vote of thanks to Mr. Smyth for his invaluable work during the year was carried by acclamation.

Report of London and Home Counties Sub-Group.—Mr. H. B. Fleming reported that the Sub-Group had held their annual general meeting at which Miss Knowles, of the Ministry of Health, had read a paper. He regretted that the attendance had been disappointing.

Report of Group Representatives on the Council of the Society.—Mr. A. G. Taylor reported that the Council had approved the Group's recommendations for amendments to the Education Act. It was proposed that Society's name be changed to the Society of Preventive Medicine. He had attended a number of meetings of the Joint Emergency Committee of the Professions in connection with the Durham County Council's "closed shop" policy.

Election of Chairman of the Group Council.—On the proposition of Mr. Webster, seconded by Mr. Fletcher, Mr. J. V. Bingay was elected Chairman for a further period of one year.

Election of Representatives on the Council of the Society.—The Hon. Secretary reported that the numerical strength of the Group only entitled them to one member on the Council. On the motion of Mr. Fletcher, seconded by Mr. Webster, Mr. Smyth was elected.

Other Business.—Mr. K. C. B. Webster gave details of the manner in which authorities with a population of over 600,000 had exercised their discretion in regard to the remuneration of Chief Dental Officers. He thought there were serious grounds for dissatisfaction on this score.

Date of Next Meeting.—This was provisionally fixed for December 6th, 1952.

BOOK REVIEWS

Milk : Production and Control. By W. CLUNIE HARVEY, M.D., D.P.H., F.R.SAN.I., and HARRY HILL, F.R.SAN.I., A.M.I.S.E., F.S.I.A. Pp. viii + 758. Price 57s. 6d. net. 1951. London : H. K. Lewis & Co., Ltd.

This is the third edition of a well-known book, first published in 1936. The text has been brought up to date and recent changes in legislation dealing with milk have been included. The authors remind us that it should never be forgotten that the cow is the original source of supply and that milk cannot be produced by any amount of legislation, however efficient that legislation may be. The trend towards more and more legislation is emphasised by the fact that whilst the chapter of the book headed "The Cow" is completed in 56 pages, that headed "Legislation" continues for 84 pages and is reinforced by the appendices.

Milk obtained from perfectly healthy cows, under the cleanest possible conditions, immediately cooled and distributed, is recognised as the best possible supply. Many factors, however, complicate the attainment of this objective. Not the least being the continued enthusiasm of the milk producer, his methodical approach to that which, after all, is an all-the-year-round activity, and the close supervision of his staff.

A considerable portion of the book is devoted to the treatment of milk by heat. The authors are of the opinion that much of the milk produced in this country would be sour before it reached the consumer unless submitted to some form of heat treatment.

It would appear obvious that there is a degree of danger where complete reliance is placed on the heat treatment of milk to cover up all the shortcomings of the cow herself, the milk producer and his staff, and those engaged in the subsequent handling of this very necessary commodity.

Information Digest. Second issue, August, 1952. Central Council for Health Education, Tavistock House North, Tavistock Square, London, W.C.1. Price 1s. 6d.

The Central Council has followed up the useful series of abstracts, summaries and references on certain topics which it issued in March this year with a second series. It is the intention to add to these by a new issue from time to time. This is one of the most constructive contributions by the C.C.H.E. and the *Digest* should become an essential reference file for those who have to construe advances in public health and medical practice or changes in social trends to the general public.

OFFICIAL NOTICES

LONDON COUNTY COUNCIL

Applications are invited from registered medical practitioners for appointment as whole-time ASSISTANT MEDICAL OFFICER in the Public Health Department. Inclusive salary £850 a year rising by annual increments of £50 to £1,150 a year, the commencing point on the scale dependent on local government service. There are not emoluments. The duties will be primarily those in connection with child health. It will be an advantage if the candidate is experienced in (i) maternity and child welfare work and (ii) the school health service, and has the Diploma in Public Health. Form of application may be obtained from the Medical Officer of Health (PH/D.1), The County Hall, Westminster Bridge, S.E.1, and should be returned by October 4th, 1952. (1000)

CITY OF NORWICH

Applications for the posts of ASSISTANT SCHOOL DENTAL OFFICERS are invited from registered dental surgeons, male or female. Salary Scale £800 per annum rising by annual increments of £50 to £1,250 per annum. Particulars can be obtained from the Medical Officer of Health, 68, St. Giles' Street, Norwich.

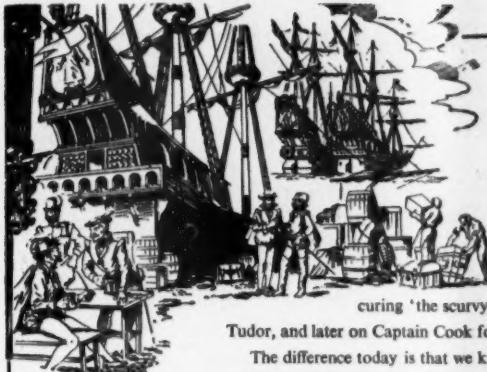
Public Health is the Official Organ of the Society of Medical Officers of Health and a suitable medium for the advertisement of official appointments vacant in the health service. Space is also available for a certain number of approved commercial advertisements. Application should be made to the Executive Secretary of the Society, at Tavistock House South, Tavistock Square, W.C.1.

Subscription 31s. 6d. per annum, post free, in advance.

Single copies 2s. 6d. post free.

Official classified advertisements are charged at 3s. 6d. per line or part of a line. Minimum charge 20s.

Telephone : Euston 3923. Telegrams : Epidauros, Westcent.



*We improve upon
the first Elizabethans..*

The virtues of 'sower oranges and lemons' in curing 'the scurvy' were known to seafarers in the days of Elizabeth Tudor, and later on Captain Cook found that fresh vegetables served the same purpose.

The difference today is that we know how much ascorbic acid we get in these foods and we can regulate our intake according to the needs of health and disease.

In VITAVEL SYRUP, concentrated orange juice is used as a base for the inclusion of other equally necessary vitamins, A, B₁, C and D, and the potency of each is designed to satisfy human needs.

One teaspoonful (3.5 c.c.) contains, at time of manufacture, vitamin A. 2,500 i.u., vitamin D 375 i.u., vitamin B₁. 0.5 mg., vitamin C. 10 mg. It can be given in water, soda water or undiluted.

VITAVEL Syrup

Available in bottles of
6 fl. oz. 3/-
40 fl. oz. 24/-
less usual
professional discount.



Clinical sample and literature available on request to

VITAMINS LIMITED (DEPT. 07P), UPPER MALL, LONDON, W.6.



**THE WESTERN PROVIDENT ASSOCIATION
FOR HOSPITAL AND NURSING HOME SERVICES LTD.**

(Mutual : Non-Profit)

(President: His Grace the Duke of Beaufort, K.G., G.C.V.O., P.C.)

invites applications for membership from anyone who wishes to make provision for:

**MAINTENANCE GRANTS FOR PRIVATE HOSPITAL WARD AND NURSING HOME SERVICES, SPECIALISTS'
PRIVATE FEES, PRIVATE OUT-PATIENT TREATMENT, CONSULTATIONS, Etc.**

No additional payment for dependants, no territorial restrictions as to residence or treatment, no age limits, no income limits. Supplementary cash payments for all illness treated in Private or General Ward and Nursing Home beds. Children are included until they leave school or university.

The Association has large reserves and is guaranteed by leading industries. It is of great help to professional men and women, enabling them to have private specialist treatment without delay and financial embarrassment.

Write or telephone for the latest and improved terms :

THE WESTERN PROVIDENT ASSOCIATION,

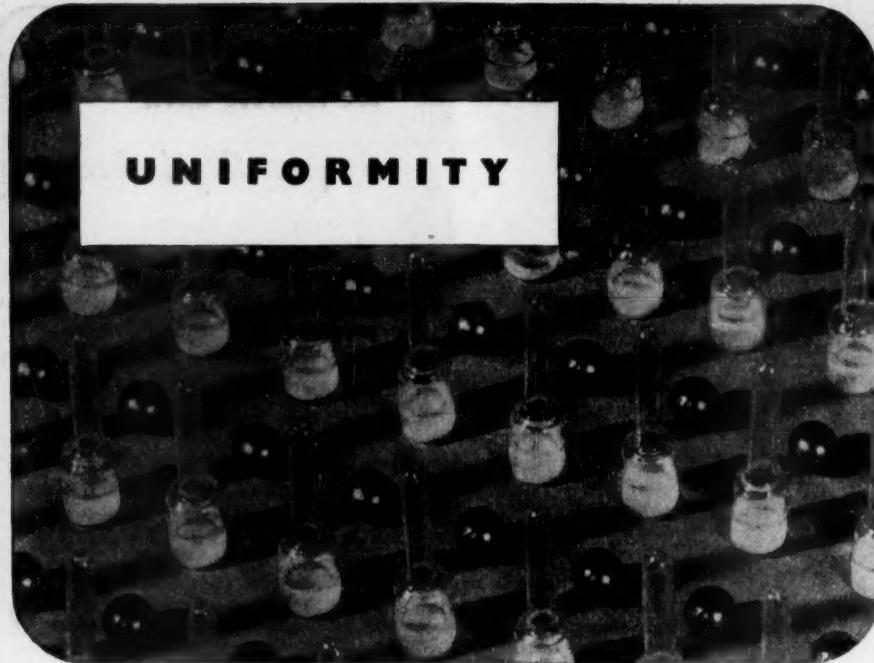
ROYAL LONDON HOUSE,

QUEEN CHARLOTTE STREET, BRISTOL, 1

Tel.: BRISTOL 23495

Secretary: JOHN DODD, B.COM., A.C.I.I.

SPECIAL SCHEME FOR THE MEDICAL PROFESSION



Prepared to standards as exacting as those used in the precision engineering of ball-bearing manufacture, 'Wellcome' Diphtheria Prophylactics are *uniform from batch to batch*. Strict control by specialists, using the most up-to-date methods, alone makes this possible. 'Wellcome' Diphtheria Prophylactics are prepared in The Wellcome Research Laboratories, where A.P.T. and T.A.F. were discovered.

'WELLCOME'^{MADE}
DIPHThERIA PROPHYLACTIC
A.P.T.

'WELLCOME'^{MADE}
DIPHThERIA PROPHYLACTIC
P.T.A.P.

'WELLCOME'^{MADE}
DIPHThERIA PROPHYLACTIC
T.A.F.

A.P.T. also combined in :-

'WELLCOME'^{MADE}
DIPHThERIA-PERTUSSIS
PROPHYLACTIC, D.P.P.

'Wellcome'— Diphtheria Prophylactics



SUPPLIED BY

BURROUGHS WELLCOME & CO. (The Wellcome Foundation Ltd.) LONDON